Royal College of Nursing and National Council of Nurses of the United Kingdom

June Clark

A Family Visitor / A descriptive analysis of health visiting in Berkshire

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A Descriptive Analysis of Health Visiting in Berkshire

By

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"In association with the general practitioner, the health visitor will be concerned with a wider range of families than any other comparable worker. She will be in touch with the various family health and welfare teams. She thus has the opportunity to act as a common point of reference and source of standard information; a common adviser on health teaching—a 'common factor' in family welfare. In the ordinary course of her work and without exceeding her competence, she could be in a real sense a general purpose family visitor."

An Inquiry into Health Visiting

Reprinted 1976

The Rcn is very happy indeed to co-operate with the Department of Health and Social Security in publishing this series of research reports. The projects were chosen by the individual research worker and the findings are those of the researcher and relate to the particular subject in the situation in which it was studied. The Rcn, in accordance with its policy of promoting research awareness amongst members of the profession, commends this series for study but views expressed do not necessarily reflect Rcn policy.

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Foreword

It is a responsibility of any profession to inquire into its activities and to find new and better ways of fulfilling its functions. This is assisted by research and by encouraging those of its members and members of other professions with relevant skills to give of their time and talents for the benefit of the profession, and indeed, of mankind.

Nurses have developed research skills a little later than some other professional people, possibly because of lack of finance and resources, probably because nurses have only comparatively recently come to appreciate the tremendous field of work awaiting critical appraisal.

Now that opportunities for acquiring research skills and carrying out research projects are more readily available the Royal College of Nursing welcomes the initiative of the Department of Health and Social Security in underwriting this new series of publications. There are so many problems to probe and so many practices to be reviewed. These present challenges, some of which have been accepted by those who will contribute to this series. It is intended that the publications will make the products of research speedily and inexpensively available to the profession both for use in nursing and as a basis for subsequent deeper exploration.

In introducing the first publication of this research series, I would like to congratulate all who are contributing to it on the work that they have achieved and to say that I feel sure that we in the nursing profession and, indeed, all who are interested in nursing will look forward with anticipation to the development of the series.

WINIFRED E. PRENTICE, O.B.E.
President
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Preface

The public image of the health professions and of nurses in particular is that they are slow to change. This is largely due to the fact that any public image is based on a stereotype which persists even when changes do occur in a group or a profession. Change in the public image is, however, influenced by change in functions. The health professions may, at times, have been slow to accept new functions and their caution, in this respect, may be justified by the fact that today's panacea may bring about tomorrow's complications. In a society, such as ours, which is subjected to rapid social, technological and other forms of change, innovations are unavoidable. Nonetheless the stereotyped image persists unless the public can be made aware of the changes occurring.

In the field of preventive medicine many substantial changes have taken place since a group of specially trained nurses undertook the duties of what today we call health visitors. They have contributed, with their colleagues in the fields of preventive medicine and social work, to the control of lethal and disabling infectious diseases, to the raising of the standards of general health, hygiene and nutrition and to a general improvement in housing and other social circumstances. These changes are reflected in the fact that the infant mortality rate in England and Wales has fallen since 1911 from 130 to less than 17 per 1,000 live births, with most deaths occurring in the neonatal period, while the proportion of the population over 65 years has risen during the same period from 5% to over 13%.

In spite of these dramatic changes there are still those—regrettably doctors and nurses among them—whose knowledge of the health visitor is either non-existent or hopelessly out of date, pertaining to a stereotype rather than to reality.

The present work, A Family Visitor, which is the first in a series of publications about nursing, for the most part based on theses accepted for degrees, is the result of a systematic study of the work of the modern health visitor. June Clark was perhaps fortunate that she was working in a county where medical and nursing leadership in the community health field has long encouraged staff to think critically about what they are doing or why. Even in these encouraging circumstances, however, it takes a lot of time, effort and perseverence to assess the data contained in the book and to present it in readable form.

It is hardly surprising that I found the book absorbing as it deals with

topics which have long interested my colleagues and myself in the academic department where we work. I believe that others with wider interests in health care research will also value the findings it contains. Those concerned with managing health services which relate to preventive medicine and health education, including the care of the chronic sick, of the physically and mentally handicapped, and of the elderly will find the contents absorbing and revealing, especially at this point in time when wide scale administrative changes are planned.

J. A. D. ANDERSON

Acknowledgements

A thesis presented for a university degree—in this case for a M. Phil in the University of Reading—is not normally in a literary form which will appeal to a general readership, even to a readership familiar with the subject matter which the thesis attempts to analyse and discuss. But the starting point of this study was a concern that the work of the health visitor was poorly understood and consequently undervalued. I would have contributed nothing to improving this situation if the thesis had remained unpublished and unread on the shelves of the university library. I am grateful therefore to the Royal College of Nursing and the Department of Health and Social Security for the opportunity to make known to others something about the work of a profession which has been contributing to the health and welfare of countless families for more than a century. In rewriting the thesis in a form suitable for publication my hope is that this study may be something more than an addition to academic knowledge.

The project was made possible by a grant from the King Edward's Hospital Fund for London—the first time that the Fund had awarded such a grant to a nurse for individual study; to them I am greatly indebted for their encouragement and generosity.

I would like to express my gratitude to Professor P. W. Campbell, Professor of Politics in the University of Reading, and Dr. V. Klein, Reader in the Department of Sociology, who jointly undertook the supervision of the degree; to Keith Freeman of the Department of Applied Statistics who advised on the statistical analysis of the data; to Miss M. Simpson who gave generously of her time and expertise to discuss and advise on the project throughout its development from the original idea to the final manuscript; to Professor Margot Jeffereys who, as external examiner in the examination for the degree of M. Phil, made many useful criticisms and suggestions which were incorporated into the re-written manuscript; to the many others too numerous to name, who discussed and commented on the project at various stages in its development; to Mrs. B. Gettings, lately County Nursing Officer, Royal County of Berkshire; and, perhaps most important of all, to the health visitors who spared some of their very precious time to complete the interviews, questionnaires, and detailed work records which form the substance of this book.

Lastly, the study would not have been possible without the constant encouragement and support of my husband; to him, therefore this book is dedicated.

JUNE CLARK

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Introduction

Controversy about the role of the health visitor has raged since before the inception of the National Health Service. Throughout its development, the guiding purpose of health visiting has remained constant—the prevention of ill-health. Within this broad framework, however, the field is so wide, the range of unmet need so great, and the formal definition of the health visitor's role so vague that there has been considerable scope for differing interpretations of her role by employing authorities, by health visitors themselves, and by other workers in the social welfare field. Uncertainties about roles and responsibilities have led to widespread anxieties among health visitors about their position in the community health services and their relationships with other branches of the social services.

The controversy and the accompanying anxieties have intensified in recent years, particularly since the publication in 1968 of the Report of the Committee on Local Authority and Allied Personal Social Services, generally known as the Seebohm Report. The changes recommended by this Committee and implemented in the Social Services Act of 1970 are already having a profound effect on the health visitor's work. The impending reorganization of the National Health Service with its transfer of responsibility for the health visiting services from local government to Area Health Authorities will bring about further changes. In these circumstances a re-appraisal of the role of the health visitor and a consideration of how it should develop in the future are particularly timely.

There is no shortage of opinions about what the role of the health visitor either now or in the future should be; there is a plethora of reports, recommendations and articles in the professional journals written by members of other professions more often than by health visitors themselves. There is, however, a dearth of factual information about the content of the present work of the health visitor. Health visitors are particularly concerned that decisions which affect their work are apparently made in complete ignorance of what health visiting really is. For example the Committee on Local Authority and Allied Personal Social Services specifically excluded health visitors from its membership and its considerations, yet stated "The main functions of the health visitor and the social worker are distinct and the two roles may be incompatible in the same person" and added "In our view the notion that health visitors might further become all-purpose social

workers in general practice is misconceived." (Committee on Local Authority and Allied Personal Social Services 1968, para. 380.)

This concern has led to the present study. Its main aims were:

1. To describe the work of health visitors in terms which would show the range of subject matter contained within the statutory duties described as "maternity and child welfare."
2. To examine the extent to which the health visitor was extending her work to groups other than mothers and young children.
3. To explore some of the anxieties expressed by health visitors about their role and their relationships with other workers in the field of social welfare.

The study examines one aspect of the work of the health visitor—the home visit—and attempts to relate it to a stereotype which portrays the health visitor as authoritarian and didactic in her approach to clients, and health visiting as an activity which is limited to maternal and child welfare and concerned primarily with the physical aspects of health. Analysis of the home visits undertaken by health visitors in Berkshire during one week in 1969 shows the origins and purposes of the visits, the topics which were raised by health visitors and their clients in different situations, the extent to which the pattern and content of the visits were influenced by external factors such as the age and training of the health visitor, and ways in which the health visitor's approach varied with different groups of clients and with different areas of subject matter. Information is also presented about some personal characteristics of the health visitors, their occupational histories, their views about their work and the patterns of communication between them and their colleagues in the field of social work.

The present work of the health visitor is discussed and related to the historical development of the health visiting service, which shows how the role of the health visitor has changed during the past century in response to changing health needs. Finally the stereotype is reviewed in the light of the findings of the study, and some implications of the findings for the organization of the health visiting service and the recruitment and training of health visitors are explored.

The question to be answered is "What is the proper function of the health visitor?" or more simply "What *should* health visitors do?" The answer to such a question must be a matter of professional policy; it is not in itself a function of research. Research can and should, however, be used to provide a basis on which decisions may be made. The present study was limited to one aspect of the health visitor's work in one county area at one particular point in time.

No-one knows how accurately it portrays health visiting at the present time in the country as a whole. Perhaps, however, it is a first small step towards finding out what health visiting is all about.

CHAPTER 1

The Stereotype of the Health Visitor

1.1 *The Components of the Stereotype*

A major factor in what Hunt (1972) has called "the dilemma of identity in health visiting" is the lack of congruence between health visitors' own perceptions of their role and a stereotype of health visiting which appears to be held by other groups. Three of the groups whose views are particularly relevant are clients, general practitioners, and social workers. The perceptions held by these three groups differ in detail, and are inevitably influenced by individual experiences, but the general stereotype of health visiting appears to comprise three main elements:

1. Clientele: the health visitor's clientele is limited to young children and their mothers, to the child within the family rather than the family as a unit.
2. Work Content: the health visitor's work is limited to maternal and child welfare, and her chief concern is with physical health and basic hygiene rather than with the psycho-social aspects of health.
3. Approach: the health visitor's approach in her relationship with clients is didactic and authoritarian rather than non-judgemental and discursive.

The belief that health visitors are concerned only with mothers and babies has been reinforced by the way in which official statistics relating to health visiting have been kept by the Department of Health and Social Security and by its predecessor, the Ministry of Health. Until 1963 the statistics were presented under the headings:

visits to expectant mothers
children 0–5 years
tuberculous households
others.

In 1964 the headings were changed, but remained inadequate, because the categories used were by no means comprehensive:

children born in the calendar year
children born in the previous five years
persons over the age of 65
mentally disordered persons
persons discharged from hospital (other than maternity)
tuberculous households.

For many years health visitors have, through their professional organizations, pressed for statistical information to be collected and presented in a way which would provide a more accurate picture of their work, so far without success; the most recent Report of the Department of Health and Social Security (1971) continues to use the same categories as its predecessors.

The impression that the health visitor is concerned with the child within the family rather than with the family as a whole inevitably develops from the practice of recording a visit to a "primary patient" rather than a visit to a family. This problem is discussed in greater detail in Chapter 6.1.

The stereotype of the content of health visiting is inevitably influenced by the stereotype of the health visitor's clientele. Views of the content of health visiting tend to be based on the assumption that in a visit to a family where there happens to be a young child discussion must be limited to the problems of the child. Moreover the term "maternal and child welfare" may be interpreted to mean no more than advice to expectant mothers and mothers with young children about matters affecting their physical welfare and child rearing practices. On the other hand it may be interpreted to include all the psychological and socio-economic factors which have a bearing on the lives of families where there happen to be young children. This problem is discussed in Chapter 7.3.

There is no evidence to support the stereotype of the authoritarian approach of the health visitor. The stereotype is probably based on perceptions of the nursing role, where the patient-nurse relationship is one of dependence and submissiveness, and on the assumption that since the basic training of the health visitor is as a nurse this approach remains unchanged when the nurse becomes a health visitor. Preliminary work carried out for the General Nursing Council by Singh and MacGuire (1971) into factors affecting career choices among different types of nurses suggests that there are substantial differences between health visitors and general nurses.

The reasons for the development of the stereotype of health visiting are probably historical. The stereotype is possibly a more accurate picture of the health visitor of the 1920s and 1930s, when the reduction of infant mortality by means of teaching and supervision of infant nutrition and hygiene was a primary aim of the health visiting service. The distribution of cheap welfare foods for children at infant welfare centres where health visitors were based may have confirmed the impression that the service was primarily for the benefit of the poor and needy. The development of the health visiting service is described in Chapter 2.

The formal definition of the health visitor's role has, however, never conformed to the stereotype. As early as 1943 in a report by a Joint Consultative Committee the health visitor's duties were defined as "the

care of the family as a unit" and the health visitor was described as "primarily a health teacher and mother's adviser; she is also a social investigator, research worker, and interpreter", and in the report commonly known as the Jameson Report the health visitor was described as "a family visitor" whose functions were "health education and social advice." (Ministry of Health 1956.)

1.2 *The Client*

We have very little written information about the consumer's view of health visiting. Clients rarely write about their perceptions of the social services except as letters of complaint or appreciation which are usually related to particular incidents and particular persons. The existence of the stereotype is usually demonstrated by the reports of verbal comments made to health visitors by their clients which regularly appear in professional journals or at professional conferences. Every health visitor will have experienced comments such as "Do you really visit old people too—I thought you just came to see the babies", or "The drains have gone wrong again and mum said to phone the welfare", or "I don't think I need a health visitor—I mean we're not poor or anything and the children are perfectly clean."

A Study by Political and Economic Planning (1961) of the consumer's view of several of the social services reported that most of the mothers who were interviewed said they had found the health visitor helpful, although apart from those who had not (11%), there was a group (a further 11%) who thought the home visit had been unnecessary. The writers quoted comments such as

"She came only to ask questions."
"She was a busybody."

Apart from this study there has been no research directed primarily at obtaining the consumer's view of the health visiting service but comments are sometimes quoted in studies concerned with related subjects. For example, Newson and Newson (1963) in discussing the influence of various people on the young mother in determining child-rearing practices, quoted the wife of a lorry driver, "a cheerful and attractive slattern, now pregnant with her fifth child [who] told us she never went to the clinic though it was barely 300 yards from her door"; the mother was reported to have said: "*They're* no good. Well just look at them. A lot of old maids, not a married one among them. They've never had any children. They don't know what it's like." In asking mothers about the role of the health visitor in the provision of advice on family planning Cartwright (1970) reported one mother as saying "I shouldn't think a health visitor would know a great deal about family planning really", and the view of another that "She should deal with just the children."

Perhaps the best (certainly the wittiest) expression of the stereotype by a client appeared in an article by Hendy (1970) first published in

World Medicine and later reprinted in the *Journal of the Health Visitors' Association*; the author, the unmarried mother of a twenty-month-old baby wrote:

"My aversion doesn't arise from a bad experience with one particular health visitor. It is their very sameness which I find so nauseating. Health visitors are like rows of identical quadruplets. They all appear to be approximately the same age; they all have neat short hairstyles and perfectly made up faces; they all wear discreet rows of pearls, navy linen suits and crisp blouses in summer—and sensible tweeds in winter. They even talk with the same voices and they say the same things. . . . The most infuriating thing is that they are so understanding and know so well how to 'deal' with people—coupled with a deadly passive resistance to criticism. . . . And they never really listen to you. Oh they appear to listen—but inside they have already pigeon-holed you and are just waiting for a gap in the conversation in which to give the appropriate advice."

1.3 *The General Practitioner*

Relationships between health visitors and general practitioners have not always been entirely cordial. In her study of social welfare services in Buckinghamshire Jefferys found that almost half of the general practitioners interviewed made critical comments about health visitors, and commented "Much of the criticism of these GPs was couched in vague terms and suggested that there was a good deal of misunderstanding or ignorance of the health visitor's functions. Many doctors seem to have started in their practices with well-rooted prejudices against health visitors." (Jefferys 1965, p. 123.) The relationship between health visitor and general practitioner and the effect of attachment to general practice on the health visitor's work is discussed in Chapter 10.

Jefferys also noted that an authoritarian approach was an important part of the general practitioner's perceptions of the health visitor. "They often expressed the view that some of their patients resented the health visitor's call, feeling that it was made on the assumption that mothers must be held to be incompetent in child rearing until the health visitor had satisfied herself to the contrary." She commented "While the popular image of the district nurse endows her with a halo and a lamp and all the qualities of saintly devotion, the image of the health visitor is still derived in part from the somewhat authoritarian supervisory role which she has played with mothers and children in the days of poverty and unemployment before the second world war." (Jefferys 1965, p. 124.)

1.4 *The Social Worker*

So far as the anxieties expressed by health visitors about their role and responsibilities are concerned, social workers probably constitute the

most important comparative reference group. The perceptions of health visiting held by social workers are relatively well documented, perhaps because the literature of social work includes many self-analyses in which the role of the social worker is defined in terms of comparisons with the roles performed by other workers.

Expressions of the stereotype of health visiting which has already been outlined are common. In particular the health visitor's approach to clients, which is assumed to be didactic and authoritarian, is contrasted with the non-judgemental approach inherent in the social worker's use of "casework" techniques. This appears to be the implication, although it is nowhere supported or explained, of the Seebohm Committee's assertion that "the main functions of the health visitor and the social worker are distinct *and the two roles may be incompatible in the same person.*" (Committee on Local Authority and Allied Personnel Social Services 1968, para. 378.)

Davison (1956) attempted to make a detailed comparison between health visiting and casework. She defined casework as: "A professional service offered to those who desire help with their personal and family problems. Its aim is to relieve stress and to help the client to achieve a better personal and social adjustment. It proceeds by the study of the individual in his social environment, by the establishment of a co-operative relationship with him, and by the mobilization of both his own resources and those of the community, to work towards those goals."

Her comparative definition of health visiting was: "A professional service offered to families in which there are young children, and also to certain elderly, infirm, sick or handicapped persons. Its aim is preventive health education and social advice. The health visitor proceeds by visiting those assigned to her, by listening to and considering the nature of the problems laid before her, by offering information and advice on all matters pertaining to health in its broadest sense, and by close co-operation with medical and social services, to promote the health and welfare of those committed to her care."

Davison further believed: "The health visitor's clientele consists of a certain group in the community deemed by the health authorities to require preventive health education. In the majority of cases the advice she has to give is offered by her not requested by her clients."

Donnison clearly saw the health visitor's work as limited to physical health problems and concentrated upon the child rather than on the family as a whole. In a study of 118 families whose children came into the care of the local authorities in Manchester and Salford he reported: "As in Manchester the health visitor's concentration on the children's physical health led them to deal chiefly with mothers and young children; they could seldom provide much information about other members of the household. . . . This isolation is a reflection of their absorption in the immediate problems of health; they need little help from other services in dealing with such problems." (Donnison 1954, p. 42, p. 107.)

In the United States role confusion between social workers and public health nurses appears to exist no less than in Britain, although the work of the American public health nurse differs from that of the British health visitor in that, in addition to health education and social advice, she undertakes practical nursing procedures in the patient's home, a role which in Britain is performed by the district nurse.

The main features of the stereotype appear to be similar. Dunbar *et al.* (1957) reported that 80% of social workers thought that public health nurses should help an expectant mother with physical needs, but only 44% that they should help with her emotional needs; 29% thought it was seldom or never the nurse's function to help parents to prepare the family for a new baby; 55% thought the nurse was seldom or never helpful in solving early behaviour problems.

Robinson (1967) investigated what activities social workers and public health nurses believed to be specifically social work, specifically public health nursing, a collaborative activity, or one which could be performed by either profession. Both groups agreed that physical illness and disability fell within the field of nursing, and economic problems within the field of social work, but social workers placed both emotional illness and social deviance in the province of social work, whereas public health nurses included the former in nursing and the latter in collaborative activities; social workers thought that the interpretation of community resources was specifically social work while public health nurses defined this as a task appropriate to either group.

Cook (1971) has remarked that two of the chief characteristics of stereotypes are first, that they are very commonly wrong all or most of the time, and secondly that they tend to be viewed over inclusively and to be rigidly held. Health visitors have long protested that both these characteristics apply to the stereotype of health visiting. The second characteristic will be for others to study, but the first characteristic provided the central purpose of this study—to find how far health visiting in practice conformed to its stereotype.

CHAPTER 2

The History of Health Visiting

2.1 *1860–1900: The Sanitary Missioner*

Health visiting began, about the middle of the last century, as the product of a union between charitable visiting and sanitary reform. Like many of the social welfare services, it began as the local effort of a few voluntary workers who attempted to deal with and to draw attention to a particular need. The voluntary organization pointed the way, and as the value of their contribution was gradually realized, the service was at first encouraged, and eventually taken over by the public authorities.

The development in England during the 19th century of an interest in public health was self-protective rather than philanthropic; it was two great outbreaks of cholera in 1832 and 1848 which, as the historian Trevelyan (1946) noted, "scared society into the tardy beginnings of sanitary self-defence."

Edwin Chadwick's report on the Sanitary Condition of the Labouring Population of Great Britain in 1842 showed that the gross inadequacy of water supplies, drainage, and facilities for the disposal of refuse in the big towns were the main sources of disease; the realization led to the first major public health legislation, the Public Health Act of 1848.

The pioneer activities of the first Medical Officers of Health, newly appointed as a result of the Act, were mirrored in the development of a number of voluntary societies. The main focus of activity, as far as the development of health visiting is concerned was in Manchester, where the Manchester and Salford Sanitary Association was formed in 1852, and a branch of the Ladies' Sanitary Association in 1861. The Manchester and Salford Sanitary Association, whose membership was confined to men, aimed to teach the laws of health by the distribution of tracts, lecturing, and district visiting. The Ladies' Sanitary Association shared the aims of the Manchester and Salford Sanitary Association but laid special emphasis on the health of women and children. At the request of the Manchester and Salford Sanitary Association, the Ladies' Sanitary Association set up a branch in Manchester in 1861, and the new branch came to be known first as the Ladies' Sanitary Reform Association and later as the Ladies' Health Society.

Records of the period are incomplete and confusing, but traditionally a description of the first health visitor has been sought in an account of

the Ladies' Health Society written in 1893 by Mrs. Hardie, a former secretary of the Society: "Its [the Ladies' Health Society of Manchester and Salford] beginning was most modest and consisted in the distribution of tracts and leaflets on health topics by three or four bodies. In the course of time they found that this in itself made little impression, and a respectable working woman was therefore engaged to go from door to door among the poorer classes of the population to teach and help them as opportunity offered." (Langton 1963.)

There are conflicting accounts both of the origins of the Association and of the date of appointment of the first "female sanitary missioner." Whatever the precise details, however, the important factor in the establishment of health visiting was the appointment of a paid employee as distinct from the "lady" visitor. Visiting as a technique of social care had been well established since the Middle Ages and during the 19th century the practice became widespread. However, middle class visitors were not always well received; Mrs. Ranyard's London Bible and Female Domestic Mission, which was to develop into London's first district nursing service, experienced the same difficulty: "Willing as she might be, the lady cannot gain admission to the homes of the greater part of our London poor. . . . It certainly seems that a native female agency, drawn from the classes we want to serve and instruct has hitherto been a missing link." (Ranyard 1861.)

At first the Association's "mission women" were completely independent of the local authority, although it was the practice to report cases of "overcrowding, delapidations, and nuisances" to the municipal sanitary department. In 1890 the Corporation of Manchester undertook to pay the salaries of six of the fourteen agents employed by the Association, and the "mission women" became known as "sanitary visitors." The following year the Association changed its own title to the Ladies' Health Society, and the title of its "sanitary visitors" to "health visitors." Finally in 1908 Manchester Corporation assumed complete responsibility for health visiting in Manchester.

The first health visitors wholly employed by a local authority seem to have been engaged by Buckinghamshire County Council in 1892. These were the product of a training scheme of which Florence Nightingale was the inspiration. Although the name of Florence Nightingale is usually associated with the development of hospital nursing, the keynote of all her writings and reforms is prevention rather than cure. "I look to the day," she wrote, "when there will be no nurses of the sick, only nurses of the well." In 1891 she wrote to her nephew, Sir Frederick Verney, who was at that time chairman of the North Buckinghamshire Technical Education Committee, outlining her ideas for a corps of "health missioners" who would "take health into the home." (Nightingale 1891.) She persuaded the Committee to start a training course under the direction of Dr. De'Ath, the area Medical Officer of Health. Sixteen ladies attended the course of sixteen lectures, twelve took the

examination, and six passed; of these, three were appointed by the County Council as full-time health visitors.

The original function of the health visitor was to teach the principles of health and the prevention of disease. The Report of the Ladies Branch of the Manchester and Salford Sanitary Association for 1880 quotes from the rules supplied to each health visitor: "They must visit from house to house, irrespective of creed or circumstances, in such localities as their superintendents direct. They must carry with them carbolic powder, explain its use, and leave it where it is accepted; direct the attention of those they visit to the evils of bad smells, want of fresh air, and impurities of all kinds; give hints to mothers on feeding and clothing their children; where they find sickness, assist in promoting the comfort of the invalid by personal help, and report such cases to their superintendent; they must urge the importance of cleanliness, thrift, and temperance on all possible occasions. They are desired to get as many as possible to join the mothers' meetings of their districts: to use all their influence to induce those they visit to attend regularly at their respective places of worship, and to send the children to school." (McCleary 1933, p. 86.)

Miss Nightingale described the work of the Buckinghamshire health missioners in a paper entitled "Sick Nursing and Health Nursing" read at the Chicago Exhibition of 1893.

"The scheme (for health-at-home nursing) contemplates the training of ladies, so called health missioners, so as to qualify them to give instruction to village mothers in:

1. The sanitary conditions of the person, clothes and bedding, and house.
2. The management of the health of adults, women before and after confinements, infants and children." (Nightingale 1893.)

During the 1890s the chief focus of the health visitor's work was environmental health and the control of infectious disease. As early as 1896 it is recorded that health visitors were active in the promotion of legislation for infant life protection although infant life protection was not formally added to their duties until 1918. In 1907 the establishment of the School Health Service added further responsibilities.

Health visiting was at this time quite distinct from nursing. In her letter to Frederick Verney in 1891 Florence Nightingale wrote: "It seems hardly necessary to contrast sick nursing with this. The needs of home health bringing require different but not lower qualifications and are more varied. . . . She must create a new work and a new profession for women." (Nightingale 1891.)

In his Introduction to the volume in which the letter was later published Frederick Verney (1892) wrote "The health visitor has not the training of a nurse, and she does not pretend to be one." Training as a nurse was not an essential qualification for health visitors in England

and Wales until 1962 although the vast majority of health visitors were registered nurses, and a nursing qualification had been required in Scotland since 1932.

Although the prime function was educative, the approach from the very beginning was neither didactic nor authoritarian. Dr. Bostock Hill, Medical Officer of Health for Warwickshire, wrote in his Annual Report for 1903: "It must not be thought that the work of the health visitor trenches in any way on the duties of the sanitary inspector or indeed any members of his staff. She is not an inspector in any sense of the word. Her functions are rather those of a friend of the household to which she gains access, and it is very gratifying to know that although at first there may have been some opposition to her entering a house, this rapidly died away, and in numerous instances she has been asked to return and aid the mothers of families by her help and counsel." (Brockington 1954, p. 117.) To the present day, the health visitor does not have, as is sometimes supposed, any right of entry to the households she visits.

The work of the earliest health visitors was thus neither limited to maternity and child welfare, nor was it based on nursing. It "could have fallen, it seems, to doctor, nurse, or social worker alike." (Ministry of Health 1956.) The health visitors of the 19th century were usually trained, if at all, as public health inspectors (the Royal Sanitary Institute, founded in 1876, had begun an examination for sanitary inspectors in 1877), but the expansion of health visiting in the early years of the 20th century was accompanied by an increasing tendency for qualified doctors and qualified nurses to enter health visiting, and soon by a growing preference of Medical Officers of Health for candidates with a nursing background.

2.2 *1900–1948: The Well-baby Nurse*

Soon after the turn of the century, however, the "female sanitary missioner" began to develop into the "well-baby nurse." The need for measures to reduce the appalling infant mortality was great; in 1899 the infant mortality rate was 163 per 1,000, the highest figure ever recorded in Britain.

As early as 1817 Dr. John Burrell Davies had opened a dispensary for the infant poor in London and had published a pamphlet in which he attributed the high infant mortality to lack of proper maternal care. The infant welfare movement—concerned with the rearing of healthy babies as opposed to the care of sick children—began in France at the end of the 19th century where Dr. Pierre Budin opened a Consultation de Nourrissons at the Charité Hospital in Paris in 1892. The first milk depot in England was set up by Dr. F. Drew Harris at St. Helens in 1899, and this was rapidly followed by others.

The main function of the depots was to promote breast feeding and, where this failed, to ensure a supply of sterilized milk for artificial

feeding. In the British depots the follow-up work was not undertaken by the centre's own staff, as in other countries; instead the women were given printed instructions and they were visited at home by health visitors.

The development of health visiting in the early years of this century is closely linked with the development of the infant welfare movement, but it was not, as is sometimes suggested, the result of it. G. F. McLeary, the chief historian of the early infant welfare movement, noted: "Though now closely associated with welfare centres, it [health visiting] had an independent beginning, and health visitors were in the field long before the first centre opened its doors." (McLeary 1935, p. 25.)

The link was due to the realization by Medical Officers of Health of the potential of a group of personnel who were already working with mothers and children as a major part of their overall function. Dr. James Niven, Medical Officer of Health of Manchester, wrote in 1923 of "a system of health visiting which I found in 1894 existing in Manchester in a form which could be, and was, gradually adapted to the purpose of maternal instruction in the care of infants." (Niven 1923.)

The first system of routine visiting to all new-born infants was begun in Huddersfield in 1905. Two women doctors were appointed by the Corporation as health visitors, and the work of these salaried officers was supplemented by eighty volunteer members of the Huddersfield Public Health Union. Following notification of a birth, each home was visited, initially by the qualified health visitor and subsequently by the voluntary worker, for the purpose of giving guidance on infant management. It was emphasized that visits must be for the health of the baby and not to dispense charity, that visits should be entirely optional on the part of those visited, and that the visits should be paid in the earliest days of life.

Reduction of mortality during the most critical period, the first few weeks of life, depended on the existence of a system whereby health visitors could know where new babies were, and until 1915 no reliable and universal system existed. The Huddersfield scheme was made possible by a system of voluntary notification to the Medical Officer of Health, which was made compulsory in 1906. The scheme was so successful that it was copied in other parts of the country. A permissive Notification of Births Act was passed in 1907, and in 1915 a second Act made notification of births compulsory over the whole country.

Health visiting rapidly became established as "the most important element in any scheme for maternity and child welfare" (MacQueen 1962, p. 866), and the Maternity and Child Welfare Act of 1918 confirmed the concentration of health visitors on this aspect of their work.

The first statutory qualification for health visitors was laid down in London in 1909 following the London County Council (General Powers) Act of 1908 which empowered sanitary authorities in London for the first time to appoint health visitors as distinct from sanitary

inspectors; until 1928, however, the statutory qualification was demanded only in London.

In 1919, the year in which the Ministry of Health was set up and the Nurses Act established a statutory qualification for nurses, health visiting was formally established as a profession; the newly-formed Ministry of Health and the Board of Education jointly promulgated an official scheme for training health visitors, and the Scottish Board of Health adopted a similar scheme. Entry to health visiting became obtainable in three ways:

(i) By one year of post-basic training for a person who was already a qualified nurse (no midwifery qualification was required at this time).

(ii) By a different one-year training for a person who was already a university graduate.

(iii) By a two-year training (later extended to two-and-a-half years with the first six months spent in hospital) for a person who was neither a nurse nor a graduate.

This variety of avenues, as MacQueen has pointed out "provided opportunity, had the community been ready to grasp it, to avoid all subsequent controversy about the types and sexes of preventive social workers." (MacQueen 1962, p. 866.) But the community was not ready; the immediate pressure was towards work in maternity and child welfare, where the efforts of health visitors were contributing greatly to a steady reduction in the infant mortality rate from its peak figure of 163 per 1,000 in 1899 to 51 per 1,000 by 1939. The trend was confirmed in 1925 by the issue of Memorandum 101/MCW which laid down that in future midwifery training was to be required for all entrants to health visitor training; to allow for the six months training in midwifery the one-year health visitor training was reduced to six months.

The resulting concentration of attention on the maternity and child welfare aspects of the work was in the short term beneficial, but in the long term disastrous. The health visitor's social and preventive training was weakened by the reduction of the post-basic course to six months to balance the extra time spent in midwifery training, and it was not increased again until the 1950s. Furthermore it removed for more than forty years the possibility of male health visitors.

The danger of concentration on the maternity and child welfare aspects of the work was cogently described by Dr. Ian MacQueen. "The danger was that, by concentration on the baby, the health visitor would come in the minds of the public and sometimes in her own mind to be simply the baby nurse, with no thought of general health teaching and social support, so that when the infant death rate had fallen sufficiently the community might imagine that her work was finished." (MacQueen 1962, p. 866.)

Dr. MacQueen's fear has been realized; although the social and

preventive aspects of health visiting were re-introduced in the National Health Service legislation and have continued to develop ever since, the stereotype of the health visitor held by many people in the 1970s is a truer picture of the health visitor of the '30s.

2.3 *1948–1972: The All Purpose Family Visitor*

The setting up of the National Health Service brought great changes and new opportunities for health visiting. During the latter part of the war while the new welfare state was in the planning stages the Joint Consultative Committee of Institutions Approved by the Minister of Health for the Training of Health Visitors and of Organizations of Health Visitors (1943) detailed the duties which it thought the health visitor should carry out in maternity and child welfare, the school medical service, tuberculosis visiting, control of infectious disease and social work; they described the health visitor's duties as "the care of the family as a unit."

The National Health Service Act 1946 re-established the preventive and social aspects of the health visitor's work and the total family unit rather than the young child as the object of her attention.

The extension of the health visitor's duties in Section 24 of the Act, opened up much wider opportunities for health visiting. This section required the health visitor, in addition to carrying out her existing functions in relation to the care of young children and expectant or nursing mothers, to give "advice as to the care of persons suffering from illness . . . and as to measures necessary to prevent the spread of infection."

Departmental circulars emphasized the intention of the Section mentioning that "illness" included mental illness and any injury or disability requiring medical or dental treatment or nursing. The circulars continued: "this involves an extension of the functions now normally assigned to a health visitor . . . after the Appointed Day she will be concerned with the health of the household as a whole." An amended and broader syllabus of training was introduced in 1950 to prepare health visitors for their expanded role.

At the same time as the health visitor's function was being extended by the National Health Service Act, other parts of the social welfare legislation of 1946–48 established services which had considerable effects on health visiting. The Children Act 1948 removed responsibility for certain aspects of child care from Health Departments; the supervision of foster children and the assessment of the suitability of prospective adopters passed from health visitors to child care officers. The National Assistance Act 1948 gave to the staff of Welfare Departments responsibility for the care of the handicapped and the elderly.

The consequent overlapping of functions caused confusion and inter-professional rivalries which were exacerbated by the fact that, whereas health visitors were required to possess a statutory qualification in

order to practice, no such requirement was laid upon the staff of Welfare or Children's Departments.

In 1953 the shortage of health visitors and the need to clarify the changed role of health visitors in the National Health Service caused the Ministers of Health and Education and the Secretary of State for Scotland to set up a working party to advise on the proper field of work, recruitment, and training of health visitors; two of the six members of the Working Party were health visitors. Its report, An Inquiry into Health Visiting (generally known as the Jameson Report) was subsequently published (Ministry of Health 1956). The report suggested that the role of the health visitor could and should be much wider than that provided by the National Health Act. The health visitor should act (as stated in the Summary of Recommendations and Conclusions, para x) as a "common point of reference and a source of standard information, a common adviser on health teaching, a common factor in family welfare. In the ordinary course of her work she could be in a real sense a general purpose family visitor." Her function was defined as "health education and social advice." (Ministry of Health 1956, para 302.)

These recommendations were accepted by the Ministry of Health and the Ministry of Education and in 1959 were commended to local health and education authorities in circulars which urged local authorities to give health visitors a larger part to play in preventing the break-up of problem families, the care of the elderly in their own homes, the home management of handicapped children, and the prevention of mental illness.

A parallel Working Party was set up in 1956 to examine the field of work, recruitment and training of the social work staff of local authority health and welfare departments. Its report, (generally known as the Younghusband Report), was subsequently published. (Ministry of Health 1959.) The terms of reference precluded anything but incidental discussion of health visiting, but the Working Party stressed the complementary nature of the work of health visitors and social workers.

Following acceptance by the Government of the main recommendations of both Working Parties, the Health Visiting and Social Work (Training) Act 1962 created a Council for the Training of Health Visitors and a Council for Training in Social Work. A single chairman was appointed for both councils and some council members were common.

At the time of the inaugural meeting of the Council for the Training of Health Visitors in 1962 there was considerable diversity in the training arrangements for health visitors. Twenty-nine training schools, the Royal Society of Health,. and the Royal Sanitary Association for Scotland were concerned in the devising of syllabuses and approval of courses; courses were organized by universities, colleges of advanced technology, technical colleges, professional organizations, and local health authorities.

The pattern of work was no less varied than the pattern of training. It ranged from that of the nurse engaged in the triple duties of nursing, midwifery and health visiting in rural areas to the complete specialization of the health visitor who was appointed to deal with only one aspect of health visiting, e.g. people suffering from diabetes, or the elderly.

The Council's first task was to prepare a new syllabus of training which would take account of changing work patterns such as the attachment of health visitors to general medical practices, and of the changing medical and social problems with which the modern health visitor was expected to deal. A new syllabus was issued in 1964 and courses based upon it came into operation in 1965.

At the same time new qualifications for entry to the courses were agreed; the candidate was required

(*a*) to be a registered nurse (the first time the nursing qualification was made compulsory), and

(*b*) to be a certified midwife or have undertaken approved midwifery or obstetric training, and

(*c*) to hold the General Certification of Education at Ordinary Level in a minimum of five subjects, or an equivalent educational qualification.

In the following year the length of the course was extended to a calendar year (an academic year followed by three months' supervised fieldwork), making the minimum period of training for qualification as a health visitor (except for a small number of students taking experimental integrated courses) four-and-a-half years.

The second urgent task of the Council was to define the field of work of the health visitor. This need was linked with the need to improve recruitment to health visiting to meet the demands for health visitors envisaged in the Ministry of Health plans for the development of local authority health and welfare services. The Third Annual Report of the Council in 1967 noted: "It is obvious that candidates will make their decision to enter training on the appeal of the work, and the lack of definition of the health visitor's role has been a barrier to many nurses. Difficulties in making this definition are considerable—the rapidly changing priorities in the social services, the increasing development of other professional workers in the associated social services, and the extended field of work in which the health visitor is expected to operate, for example in co-operation with the general practitioner, all combine to present a confused picture. In addition, the specific contribution of nurse and midwifery training to the whole preparation of the health visitor has not been analysed." (The Council 1967.)

The Council in 1967 produced a brief pamphlet, *The Function of the Health Visitor*, and this was considerably expanded in 1969 by *The Health Visitor: Her Function and its Implications for Training*. (The

Council 1959). The Council identified the five main aspects of her work as:

(*a*) the prevention of mental, physical, and emotional ill-health or the alleviation of its consequences;

(*b*) early detection of ill-health and the surveillance of high risk groups;

(*c*) recognition and identification of need, and mobilization of resources where necessary;

(*d*) provision of care; this will include support during periods of stress, and advice and guidance in cases of illness as well as in the care and management of children.

Meanwhile major developments in the related fields of medicine and social work were taking place which had considerable implications for health visiting.

The first was the development of the concept of the "family health team", a multidisciplinary team which would operate within the framework of general medical practice to provide comprehensive primary medical care. During the early 1960s there began an accelerating tendency for general practitioners to join together in groups working from the same premises; from 1966 onwards the arrangement was encouraged by financial incentives. In 1952 44% of all general practitioners were working in single-handed practices and a further 33% were working with a single partner; only 23% were working in groups of three or more. By 1968 the proportion in single handed practice had fallen to 23% and the proportion working in groups of three or more had risen to 50%.

The development of group practice made possible the implementation of recommendations made as early as 1920 that general practitioners and local authority health services should come together under one roof to provide a more co-ordinated service. The Jameson Report in 1956 had urged that health visitors should work more closely with family doctors, and the Report of a Joint Working Party of the Royal College of General Practitioners and the Royal College of Nursing (1961) noted that "Understanding and teamwork is steadily increasing and a number of interesting experiments and activities are being carried out in various parts of the country, bringing health visitors and family doctors together as working partners."

The organizational pattern which developed has become known as "attachment", which is defined as "a system which enables nurses, health visitors, and midwives to work in partnership, with doctors, providing medical services and preventive services to the population they serve, defined not by a geographical district but by patients on the doctors' lists." (Department of Health and Social Security 1968, p. 152.) In 1967 the Minister of Health urged local authorities to do all they could to further the joint working of nursing staff with family doctors, and the Health Services and Public Health Act 1968 removed the legal

difficulties of the public health nurse's place of work and local authority administrative boundaries. In 1961 a few experimental attachment schemes were in operation; by October 1971 60% of health visitors were working in attachment schemes. There is still, in a few areas, resistance to the concept of attachment, and there are a number of practical difficulties, especially in urban areas, but it seems clear that attachment will be the administrative framework within which all health visitors will eventually work.

The second development was a movement towards co-ordination in the non-medical personal social services. The Younghusband Report had stated the case for developing the varied and scattered range of social work jobs into a unified profession, and numerous studies and reports during the early 1960s showed that social workers were as concerned about fragmentation of services within their field as doctors and nurses were within theirs. Finally in 1965 the Committee on Local Authority and Allied Personal Social Services, under the chairmanship of Mr. Frederick Seebohm was set up "to review the organization and responsibilities of the local authority personal social services in England and Wales and to consider what changes are desirable to secure an effective family service." The Committee, (generally known as the Seebohm Committee) reported in 1968, recommending that a new Social Services Department should be set up by each local authority; the new department would undertake the existing work of the Children's Department and the Welfare Department, education, welfare, and several of the responsibilities of the Health Department (the day care of children under five, social work with the mentally ill, handicapped, and elderly, and the administration of the home help service) which were previously carried out by health visitors. The recommendations were implemented in the Local Authority Social Services Act 1970.

CHAPTER 3

The Study

3.1 *Design of the Study*

An accurate and comprehensive description of health visiting would have required a detailed study of all aspects of the work of a large number of health visitors working in different geographical areas and in different administrative settings. Such a project would have been far beyond the resources which were available for this study. Accordingly it was decided to study the population of health visitors employed in a single local authority area, the Royal County of Berkshire.

Three characteristics made Berkshire especially suitable as a study area:

1. size: the area was small enough to allow all the health visitors employed to participate in the study rather than a sample, while the population of health visitors was large enough to permit comparisons between different groups of health visitors;
2. geographic and demographic characteristics: Berkshire is partly urban, partly rural; it includes a new town, several ancient market towns, and newly developed residential areas, and parts are within the metropolitan commuting belt;
3. administrative policy: the policy of attaching health visitors to general medical practices was well established; with very few exceptions (which occurred at local authority boundaries where cross-boundary arrangements had not yet been agreed) all health visitors were working in complete attachment schemes.

Scrutiny of published studies showed that information was already available about certain aspects of the health visitor's work, notably the allocation of time to various activities and the characteristics of the families they visited. Very little information, however, was available about the actual subject matter discussed during the contacts between health visitors and the families they visited; since this study was undertaken a study of the work of health visitors in London has provided further information (Marris 1969).

It was decided, therefore, to make the content of the home visit the main focus of the study, but to obtain in addition some background information about the health visitors themselves, their views about their work, and their relationships with other health and welfare services.

Accordingly each health visitor was interviewed by the writer, and was asked to complete a questionnaire and a record of all home visits undertaken during one week. The data was collected between the middle of May and the middle of July 1969.

3.2 *Population and Response Rates*

All the health visitors employed by Berkshire County Council at 1st May 1969 were invited to participate in the study, including those who worked part-time, but excluding:

(i) administrative staff who did not carry a caseload;

(ii) specialist health visitors (chest, geriatric, and premature baby visitors);

(iii) combined workers (a small number who combined health visiting with midwifery duties).

This yielded a population of eighty-two health visitors.

Two health visitors declined to participate and one was away sick throughout the period of the study. The remaining seventy-nine health visitors were interviewed, a response rate of 96·3%. Seventy-eight questionnaires were returned, a response rate of 89·1%. Seventy-two health visitors returned records of their home visits, a response rate of 87·8%. Records were obtained of 2,057 visits.

3.3 *The Development of Instruments*

The information in this study was collected by means of three instruments—a postal questionnaire, an interview, and a "visit schedule." The three instruments are reproduced as an Appendix. They were tested in small-scale pilot studies in Reading, Marlow, and Beaconsfield.

The development of an instrument to measure the content of the home visit was a particularly difficult task. Work which consists of professional/client communication within the totally unstructured framework of a home visit is not susceptible to normal techniques of work study. The most accurate and objective method of recording such information is by means of direct observation; but the introduction either of a third person or of a tape recorder is an intrusion which inevitably distorts the content of the conversation; probably to the extent that in a study which was attempting to record what *normally* happened it would invalidate the data which it was attempting to collect. Similar distortion is believed to occur in visits where the health visitor is accompanied by a student health visitor. For this reason direct observation was rejected.

At least one study of the health visitor's work, that commissioned by the Jameson committee and described in their report "An Inquiry Into Health Visiting" (Ministry of Health 1956) had used the diary method for collecting data. This method was rejected for three reasons:

the data produced are highly selective, statistical analysis of the data is exceedingly difficult, and the time taken to compile diary records would have precluded a sufficiently large sample of visits.

The instrument which was finally devised was a "visit schedule"—a record, completed by the health visitor for each visit, which as well as obtaining information about the background to the visit (the type of client, purpose of the visit etc.) would record the content of the visit in terms of the topics discussed and the communication techniques used.

The idea of measuring the content of the visit in terms of the topics discussed and the communication techniques used was suggested by Johnson and Hardin's study of the verbal behaviour of a sample of 157 American public health nurses and their clients in 287 home visits (Johnson and Hardin 1962). The observation technique employed by Johnson and Hardin involved the use of a portable tape recorder which reproduced the verbal exchange between nurse and patient or among a larger group, and the co-ordination of verbal material with a description of non-verbal behaviour and environmental dynamics visually perceived by a nurse observer. Analysis involved the use of an abstracting system, followed by classification into "subject matter sequences" of each visit portion according to the dominant topics which arose, and classification of the processes of interaction between nurse and patient into "dimensions of verbal involvement"; "content" and "dynamics" were thus described. The data were transferred in summary form to worksheets which were then used as code sheets for card punching.

In discussing the methodology of their study Johnson and Hardin commented that they had to develop almost in its entirety their own scheme of analysis for processing data recorded verbatim: "We found that few investigators who have analysed verbal data have displayed interest in careful and detailed classification of topics or subject matter at a simple and uncomplicated level. One would think that the substance of conversations would receive equal treatment with the underlying dynamics. This would seem to be especially true in the health field where omissions of certain topics can be assumed to be crucial in evaluating quality of care. Nevertheless, for whatever reasons, we found this aspect of verbal behaviour largely ignored." (Johnson and Hardin 1962.)

Resources necessary for methods of processing as complicated as those employed by Johnson and Hardin were far beyond the scope of this study. It was considered, however, that the idea could be incorporated into a simple self-administered record form. It was important to devise a form which would yield as detailed a picture as possible of the visit, but which could be completed by the respondent in a few minutes. This was necessary if respondents were to be asked to record a large number of visits because it was considered that excessive demands on the health visitor's time would not only distort her pattern of work but would also lower the response rate and reduce the accuracy of the data. Furthermore it was considered that the accuracy and completeness of

the data would decrease as the interval between the visit and the recording of it increased; respondents were asked to complete at least the "content" part of the schedule immediately after the visit.

In addition to these limitations, any self-administered instrument is open to criticism on the ground of subjectivity. The data recorded by the health visitor gives only the health visitor's perceptions of what actually happened; for practical reasons it was not possible in this study to obtain the client's view of the visit. In particular a subjective assessment of "level of verbal involvement", (see Chapter 8), can only be regarded as a very crude measure of the health visitor's approach. The same criticism, however, applies to the diary method, and given the objections to the use of direct observation which have already been discussed, the limitation was inevitable.

It proved impossible to devise an instrument which satisfied all the desirable criteria. Nevertheless it is suggested that the use of this "visit schedule" did provide information about a very large number of visits in far greater detail than was previously available. It is possible that it could be improved and refined for use in further studies of health visiting, and perhaps even developed into an instrument which could be used (see Chapter 7.1) in assessing standards of care.

3.4 *Analysis*

The data obtained from the interviews and questionnaires was transferred to edge-punched Cope-Chat cards which were sorted by hand. The data contained in the visit schedules was processed by means of the University (ICL/4130) computer, using a programme specially written for the project.

The Department of Applied Statistics of the University of Reading provided advice on the statistical analysis and presentation. Standard statistical tests (the X^2 test) were applied, using the computer, to assess the significance of differences; no result is referred to as significant unless the probability of it occurring by chance was less than one in fifty cases (i.e. $P = 0{\cdot}02$).

CHAPTER 4

The Health Visitors and their Views about their Work

All the health visitors who agreed to participate in the study were interviewed in order to obtain general background information and to explore their views about their work. In an attempt to avoid interviewer bias the interview was highly structured. A written record was completed during the interview, and, except in the very few cases where those interviewed were unwilling, the interview was tape-recorded.

4.1 *Personal Characteristics*

Of the seventy-nine health visitors who participated in the study, sixty-four were working full-time, and fifteen part-time. Their age and marital status is summarized and compared with the findings of other studies in Tables 1 and 2. Their dates of qualification as health visitors are shown in Table 3.

TABLE 1

Age of Health Visitors

Age	Berkshire 1969 (present study)		(*a*) 2 Rural Counties and 1 County Borough 1969	(*b*) All Local Authorities 1966
	Number	Percentage	Percentage	Percentage
Under 30 years	6	7·6	4	9·8
30–39 years	22	27·8	22	24·2
40–49 years	25	31·6	47	33·7
50 years and over	22	27·8	27	32·3
not specified	4	5·1		
Total	79	100·0	100% = 51	100% = 8,788

(*a*) Walker, J. H. and McClure, L. M. (1969). Community Nurses View of General Practice Attachment. *British Medical Journal*, **3**, 584.

(*b*) Unpublished statistics supplied by the Council for the Training of Health Visitors.

TABLE 2

Marital Status of Health Visitors

Marital Status	Berkshire 1969 (present study)		(*a*) 2 Rural Counties and 1 County Borough 1969	(*b*) All Local Authorities 1966
	Number	Percentage	Percentage	Percentage
Single	38	48·1	47	63
Married	35	44·3	51	
Widowed	3	3·8	2	37
Divorced or Separated	3	3·8		
Total	79	100·0%	100% = 51	100% = 8,788

(*a*) Walker, J. H. and McClure, L. M. (1969). Community Nurses View of General Practice Attachment. *British Medical Journal*, **3**, 584.

(*b*) Unpublished statistics supplied by the Council for the Training of Health Visitors.

TABLE 3

Date of Qualification as Health Visitor

Date of Qualification	Number	Percentage
Before 1950	13	16·4
1950–1959	19	24·1
1960–1965	21	26·6
Since 1965	23	29·1
Not specified	3	3·8
Total	79	100·0

TABLE 4

Qualifications of Health Visitors

Qualifications	Number	Percentage
Minimum qualification only	19	24·1
State Certified Midwife (SCM)	45	57·0
District Nurse training (QIDN)	27	34·2
Registered on two parts of the Register of the G.N.C. (RSCN or RMN)	10	12·7
Fieldwork Instructor	15	19·0
Other	16	20·3

Note: Multiple answers possible, therefore total exceeds 100%.

More than 60% of the health visitors were aged forty and over; more than a quarter were aged fifty and over. Yet only 40% had been qualified as health visitors for longer than ten years. This pattern is a reflection of the considerable previous professional experience of many health visitors and possibly also of the pattern of the return to work by married women after the "family break"; these findings are also related to the additional professional qualifications of health visitors (Table 4) and factors affecting choice of health visiting as a career (Table 5). The proportion of married health visitors (Table 2) reflects trends which are clearly seen in other forms of employment of women, and in health visiting, as in other forms of employment, the trend is accelerating; of the student health visitors who commenced training in 1967 and 1968, 48% were married. It is also noteworthy that while all but three of the part-time health visitors were married, two-thirds of the married health visitors were working full-time.

TABLE 5

Reasons for Entering Health Visiting

Reason	Mentioned Spontaneously		Mentioned Spontaneously or in Answer to Check List	
	Number	Percentage	Number	Percentage
Salary	3	3·8	6	7·6
Convenient hours	27	34·2	33	41·8
Marriage	5	6·3	5	6·3
Other domestic/family commitments	3	3·8	3	3·8
Health reasons	5	6·3	5	6·3
Experience abroad	6	7·6	6	7·6
District nurse experience	2	2·5	2	2·5
Interest in babies	7	8·9	27	34·2
Negative feelings towards hospital	22	27·8	34	43·0
Dislike of practical nursing	3	3·8	24	30·8
Interest in preventive work	8	10·1	43	54·4
Desire to care for "the whole patient"	24	30·4	49	62·0
Independence as a practitioner	5	6·3	37	46·8
Further training/career prospects	17	21·5	37	46·8
Other	1	1·3	5	6·3

Note: Multiple answers possible, therefore total exceeds 100%.

The qualifications possessed by the health visitors in addition to their minimum qualifications (S.R.N., H.V. Cert) are shown in Table 4. Twenty-eight health visitors (35%) held one additional qualification, 24 (30%) held two, and eight (10%) held three.

4.2 *Occupational History*

Respondents were asked four questions about their occupational history; whether, before becoming nurses, they had considered going into any other occupation, at what point in their nursing careers they had decided to become health visitors, the reasons why they became health visitors, and whether they would make the same decision if they could have their time over again.

The answers to the first question are of limited value, as it is known that answers to such questions are frequently influenced by the respondent's prestige feelings. Nevertheless it is perhaps noteworthy that thirteen respondents said that they had considered medicine, and ten that they had considered social work; how far the rejection of these careers had been due to lack of opportunity, inadequate educational attainment or other factors was not investigated.

The decision to become a health visitor had usually been taken late in the respondent's nursing career. Only nineteen (24%) had made the decision before, during, or immediately after their basic nurse training. Twelve (15%) linked the time of decision to working as a midwife, eight (10%) to working as a district nurse and five (6%) to returning to England after working abroad. The time of decision is obviously related to the reasons behind the decision.

The reasons which the respondents gave for their entry to health visiting are summarized in Table 5. Most respondents gave at least one reason spontaneously, but in addition a check list of possible reasons was presented; responses in both categories are tabulated. The reasons most frequently mentioned spontaneously were convenient hours, a wish to "care for the whole patient", and further training or career prospects, but when responses in answer to the check list are included, "care of the whole patient", and an interest in preventive work were the most commonly recorded reasons.

Some of the terms listed require explanation. Many of the health visitors expressed dissatisfaction with their previous hospital nursing experience not because of any personal constraints experienced as a result of working within an institutional environment but because they felt that their care of patients was incomplete and unreal in that it was orientated towards a single individual divorced from his normal environment, and because the rapid turnover of patients in hospital prevented the development of satisfactory nurse/patient relationships; these views were frequently expressed in rather vague and imprecise terms, but were coded as "care of the whole patient." Where views about the difficulties of working in the hospital environment ("I couldn't stand the system") were expressed these were coded as "negative feelings towards hospital." It is perhaps interesting that health visitors who had previously worked as district nurses or district midwives did not express the former type of dissatisfaction and commented that "care of the whole patient" applied to all community work.

The desire for convenient hours was not limited to married health visitors; some unmarried health visitors had family commitments such as elderly parents, and almost half of all the health visitors agreed, when asked directly, that convenient hours was an important factor. Where "health" was specified as a reason, it was usually associated with a back injury sustained during hospital work. Further training and career prospects was specified by several health visitors who had previously worked as triple-duty nurses (midwife, district nurse and health visitor) in rural areas without the health visiting qualification and who had been affected by policy decisions made by Berkshire some years ago that triple-duty workers should be required to undertake health visitor training and that health visitors should not carry district nursing commitments.

It is noteworthy that "special interest in preventive work" was mentioned spontaneously by only eight (10%) respondents, but agreed in response to the check list by the majority (54%). Although the responses were recorded as reasons for entering health visiting, it appeared that understanding and appreciation of the value of preventive work had come during training and experience as a health visitor. It is probable that all reasons recorded were influenced by experiences since the decision was made and failures in memories of motives which for many of the health visitors had been important many years ago.

Sixty-seven (85%) of the health visitors would in retrospect still go into health visiting, although seventeen (21·5%) expressed some reservations; three (3·8%) were uncertain, and nine (11%) would not. Of the twelve who were either uncertain or would not choose the same career again two said that they would not now go into nursing at all, but that if they did find themselves in nursing they would prefer health visiting to any other form of nursing; four described themselves as "a nurse at heart" and all these were trained district nurses who had spontaneously given "career prospects" as a reason for entering health visiting; three said they would have preferred to do social work; and three said "not health visiting as it is now" although they did not specify why.

4.3 *Satisfactions and Dissatisfactions*

Information was next sought as to which aspects of the health visitor's work were liked and disliked. Respondents were given a card bearing a list of activities and asked to rank them in order of preference, followed by a card bearing a list of different types of clients, with the same request. The health visitors found great difficulty in answering these questions; thirteen claimed they had no preferences in terms of activity, and eighteen that they had no preferences among types of clients; most were prepared to express a positive dislike of at least one activity, but almost none were prepared to express a positive dislike of a particular group of clients. For these reasons, and because the results were consequently

difficult to analyse quantitatively, the value of the findings is limited, but the results are summarized in Table 6 and Table 7.

TABLE 6

Preferences Expressed by Health Visitors about Activities and Clients

Activities and Client Groups	Health Visitors Ranking Activity or Group First or Second	
(*a*) Activities Ranked First or Second	Number	Percentage
Visiting babies and young children at home	39	49·3
Supporting and counselling families	36	45·6
Group teaching	14	17·7
Advising on prevention of disease	11	13·9
Acting as liaison agent	9	11·4
Infant welfare clinics	3	3·8
No preferences expressed	13	16·5
(*b*) Client Groups Ranked First or Second		
Young babies	25	32·1
Families with social problems	25	32·1
Toddlers	18	22·8
Old people	15	19·0
Mentally ill	11	13·9
Mentally subnormal	5	6·3
Physically handicapped	4	5·1
Chronic sick	2	2·5
No preferences expressed	18	22·8

TABLE 7

Activities about which Health Visitors expressed a Positive Dislike

Activity	Health Visitors who expressed a Positive Dislike	
	Number	Percentage
Group teaching	25	30·4
Infant welfare clinics	15	19·0
Acting as liaison agent	5	6·3
Visiting babies and children at home	2	2·5
Advising on prevention of disease	1	1·3
Supporting and counselling families	1	1·3

Young babies as clients, and visiting babies and young children at home as an activity, were the most preferred, closely followed by families with social problems as clients, and supporting and counselling families as an activity. In enlarging upon their preferences respondents generally stressed that home visiting, whatever the type of client, was the activity which they preferred and which they considered most important. Although young babies were most often preferred as clients (ranked equally with families with social problems), work in infant welfare clinics was ranked second among the activities positively disliked. Group teaching was ranked third among activities preferred, and first among activities positively disliked; this apparent inconsistency is explained by polarization of views among the group—respondents tended either to like teaching very much, or to dislike it very much, rather than to feel neutral.

4.4 *Four Possible Roles*

Opinions were next sought about the future role of the health visitor. Information was obtained in terms of agreement or disagreement with four possible roles as described by Draper (1969) in an article published in the *Nursing Times* entitled "The Health Visitor After Seebohm." The four possibilities were not originally suggested by Draper; the general concepts had been widely discussed at professional conferences and in the correspondence columns of nursing and medical journals for some time, and one, that of the "community nurse" was suggested by both Jefferys (1965) and Wenborn (1966). The four possible roles were described as follows:

1. "A community nurse who would combine health visiting with skilled home nursing and the supervision of the home nursing done by S.E.N.s."
2. "A children's visitor whose responsibility would be for the physical and emotional development of children under five."
3. "A medico-social worker for all age groups in addition to her special responsibility for children under five."
4. "A preventive health nurse who would carry out existing duties in relation to infant care, but would take on additional duties in screening procedures and an expanded amount of formal health education."

Respondents were asked what they thought about each "role", as described by Draper, in turn; finally they were asked which of the four possibilities they preferred. The results are summarized in Table 8.

The general disagreement expressed by the respondents with the concept of the community health nurse supports the findings of Downs (1968) who carried out a survey among members of the Health Visitors Association, and the reasons given for such disagreement were similar.

TABLE 8

Opinions expressed about the Future Role of the Health Visitor

(*a*) Opinions about each of Four Roles described by Draper

	Community Nurse		Children's Visitor		Medico-Social Worker		Preventive Health Nurse	
	No.	%	No.	%	No.	%	No.	%
Agree	10	12·8	4	5·1	65	83·3	27	34·6
Uncertain	6	7·7	0	0	8	10·3	16	20·5
Disagree	62	79·5	74	94·9	5	6·4	35	44·9
Total*	78	100·0	78	100·0	78	100·0	78	100·0

* This question was not answered by one respondent; the total number of replies was therefore seventy-eight.

(*b*) Role Preferred out of Four Possible Roles Suggested

Preferred Role	Number	Percentage
Community nurse	6	7·7
Children's visitor	3	3·8
Medico-social worker	49	62·8
Preventive health nurse	10	12·8
Combination/don't know	10	12·8
Total*	78	99·9

* This question was not answered by one respondent; the total number of replies was therefore seventy-eight.

Most respondents believed that in such a situation acute curative work would have to be given priority at the expense of preventive work and health education, and several expressed the view that when medicine and technical nursing was changing so fast it would be impossible to maintain expertise in two fields. Those who agreed with the suggestion talked of increased job satisfaction and better use of their nursing skills; of the six respondents who would choose this role, four had said earlier in the interview that they would not now go into health visiting and had described themselves as "a nurse at heart."

Those who disagreed with the concept of the children's visitor suggested that this would be too narrow a role; and some commented that one attractive feature of health visiting work at present was its variety. Those who would choose this role had previously expressed a special interest in young children; all were also State Registered Children's Nurses.

Many of the sixty-five health visitors who agreed with the concept of the medico-social worker commented spontaneously "but this is what we are already"; several of those who agreed, and most of those who expressed uncertainty, considered that a considerable reduction in caseloads would be necessary.

The "preventive health nurse" role was not well understood. Some of those who rejected it did so on the ground that they disliked group teaching, and some on the ground that screening procedures could be carried out by less well qualified workers or by technicians. Those who would choose this role emphasized that prevention was the most important part of health visiting.

4.5 *The Difference between Health Visiting and Social Work*

The final part of the interview, which was concerned with the health visitors' views about the relationship between health visiting and social work was included in an attempt to explore an area for further study rather than to provide information which would be useful for this study. The replies were not subjected to detailed analysis, but some details are included here as useful illustration of the kind of anxieties felt by health visitors about their relationships with other social agencies.

Only ten respondents considered that there was no overlap between health visiting and social work. Almost half considered that they were qualified to do the work that social workers did, usually in the belief that they were doing it already or on the ground that few social workers had any qualification to do the work which they were doing beyond experience, which the health visitor also shared; none, however, considered that a social worker was qualified to undertake health visiting.

Most of the respondents agreed, however, that there was a difference between social work and health visiting, but were unable to define the differences with any precision. The differences were usually described in terms of depth (e.g. that because the social worker had a smaller caseload she was able to deal with problems in greater depth, and that health visiting did not include casework), problem orientation (e.g. that the social worker dealt only with problems whereas the health visitor worked with normal families, and that the social worker's intervention in a family was short-term, at a time of crisis), and background science (e.g. the health visitor is interested in health which includes emotional and social well-being while the social worker is interested only in the social aspects, or that the health visitor has a medical background). An attempt to summarize the frequency of such comments is made in Table 9. Comments included several expressions of hostility (e.g. "They sit in an office most of the day and write long case-histories"). It is noteworthy that not a single respondent expressed the difference in terms of the age of the client; six went so far as to describe the health

TABLE 9

Differences between Health Visting and Social Work

Factors of Difference Mentioned	Health Visitors Mentioning Factor	
	Number	Percentage
Very little difference between them	14	17·7
Health visitor has a medical orientation	13	16·5
Social worker intervenes at crisis point	9	11·4
Health visitor deals with normal families, social worker with problems	7	8·9
Social workers have smaller caseload	21	26·6
Social workers do casework, health visitors do not	23	29·1
Health visitors have a more practical approach	3	3·8
Health visitor is a generalist, social worker is a specialist	4	5·1
Health visitor is a family visitor, social worker deals with individuals	6	7·6
Social workers spend more time in the office/write long case histories/hand out money	11	13·9

visitor as orientated towards the whole family while the social worker tended to concentrate on the individual delinquent, the individual handicapped or old person or the children.

One health visitor summed up the situation as follows: "We complement each other. The health visitor is a long term visitor; the social worker comes in and out as crises arise. Also the health visitor gets a wide view of the normal in an area, she has a 'feel' about an area which a social worker wouldn't have. And of course, we have a medical background. . . . Yes I think a health visitor could easily do the sort of work that a social worker who has just had two years training could do, but the health visitor couldn't be a caseworker—that demands extra training."

CHAPTER 5

Communication Between Health Visitors and Other Social Agencies

5.1 *Introduction*

It is possible that conflict between health visitors and social workers about their respective roles is aggravated by a lack of communication between them. In particular health visitors complain that social workers rarely contact the health visitor about families with whom they must know the health visitor is already in contact (e.g. any family where there is a child aged under five years) and that when health visitors refer a family for specialist social work help they rarely receive any follow-up report of the family's progress.

In order to explore these suggestions, which were relevant to the main study although not an integral part of it, a questionnaire was sent to all the health visitors to be completed prior to their interview with the author. Respondents were asked with which of a long list of other agencies they had been in contact during the previous month and during the previous week, and then to answer a series of questions about the most recent contact with each of four selected social agencies; they were also asked whether they had any regular meetings with social workers and if so to specify the type of meeting; seventy-eight questionnaires were received, a response rate of 95·1%. A copy of the questionnaire is included in the Appendix.

Contact with other agencies as recorded by the health visitors is shown in Table 10.

The number of agencies with whom the health visitors had been in contact was very great; 85·5% of health visitors had been in contact with ten or more different agencies during the previous month, and almost half (48%) had been in contact with ten or more agencies during the previous week. The highest "rate" of contact was, as might have been expected, with other members of the practice team; all but one of the health visitors had been in contact with the general practitioner during the previous week. Contact with social workers was also high—more than half the health visitors had been in contact with both the Children's Department and the Welfare Department during the previous week.

TABLE 10

Contact with Other Agencies during previous Month and previous Week

Agency	Number of Health Visitors Recording Contact			
	During previous month		During previous week	
	(*a*) Number	Percentage	(*b*) Number	Percentage
General practitioner	76	100·0	74	98·7
Midwife	69	90·8	63	84·0
District nurse	73	96·1	60	80·0
Medical-social worker	57	75·0	33	44·0
Hospital (other than M.S.W.)	39	51·3	26	34·7
Psychiatric social worker	25	32·9	16	21·3
School Health Department	60	78·9	30	40·0
Public Health Inspector	15	19·7	4	5·3
Home Help Organizer	71	93·4	59	78·7
Children's Department	62	81·6	41	54·7
Welfare Department	65	85·5	46	61·3
Education Department	33	43·4	13	17·3
Education Welfare Officer	17	22·4	6	8·0
Child Guidance	30	39·5	23	30·7
Ministry of Social Security	36	47·4	15	20·0
Housing Department	48	63·2	22	29·3
Probation Officer	21	27·6	11	14·7
Police	10	13·2	6	8·0
Meals on Wheels	51	67·1	32	42·7
British Red Cross	38	50·0	20	26·7
W.R.V.S.	43	56·6	23	30·7
Family Planning Association	27	35·5	4	5·3
Moral Welfare Worker	25	32·9	7	9·3
N.S.P.C.C.	5	6·6	1	1·3
Old People's Welfare Committee	29	38·2	19	25·3
Council of Social Service	3	3·9	2	2·7
Other statutory service	12	15·8	5	6·7
Other voluntary organization	29	38·2	14	18·7

(*a*) Two health visitors had been off sick for the past month; replies to this question therefore totalled seventy-six.

(*b*) One further health visitor had been on holiday for the past week; replies to this question therefore totalled seventy-five.

5.2 *Communication with Four Selected Agencies*

The four agencies selected for more detailed investigation were the Children's Department, the Welfare Department, hospital medical social workers, and the voluntary organizations. The first two were selected because in Berkshire in 1969 these agencies were responsible for all the social work services provided by the local authority: the

officers of the Welfare Department were responsible both for mental welfare and for duties in respect of the elderly, the homeless, and the handicapped; the Child Care Officers were responsible for family casework in addition to their duties in connection with the care of children deprived of a normal home life. Medical social workers were selected because it was known that health visitors had responsibilities in the care of patients discharged from hospital. Voluntary organizations were included to discover the extent to which their services were used by health visitors and for what reasons.

Respondents were asked to describe the most recent contact with each of these four agencies in terms of recency, initiation, method of communication, and whether the family was already known to the agency involved; some additional questions were asked about voluntary organizations. The questionnaire stressed that "most recent contact" included both the agency contacting the health visitor and the health visitor contacting the agency. The findings are summarized in Tables 11–14.

TABLE 11

Recency of Contacts with Four Selected Agencies

Expressed as Percentage of Total Contacts Described in Each Group

Recency of contact	Children's Dept.	Welfare Dept.	Medico-Social Workers	Voluntary Organizations
Within last week	44·7	54·8	40·0	45·1
1–4 weeks ago	37·3	34·2	40·0	39·4
1–6 months ago	10·7	9·6	17·3	12·7
6–12 months ago	4·0	1·4	2·7	—
More than 1 year ago	1·3	—	—	1·4
Not specified	—	—	—	1·4
Total	100% = 75	100% = 73	100% = 75	100% = 71

TABLE 12

Initiation of Contacts with Four Selected Agencies

Expressed as Percentage of Total Contacts Described in Each Group

Initiator of contact	Children's Dept.	Welfare Dept.	Medico-Social Workers	Voluntary Organizations
Health visitor	72·0	78·1	28·0	83·1
Agency	25·3	15·1	72·0	14·1
Not specified	2·7	6·8	—	2·8
Total	100% = 75	100% = 73	100% = 75	100% = 71

TABLE 13

Method of Communication in Contacts with Four Selected Agencies
Expressed as Percentage of Total Contacts Described in Each Group

Method of communication	Children's Dept.	Welfare Dept.	Medico-Social Workers	Voluntary Organizations
Letter	8·0	11·0	16·0	18·3
Telephone	53·3	27·4	72·0	39·4
Face-to-face	32·0	56·2	8·0	35·2
Not specified	6·7	5·4	4·0	7·1
Total	100% = 75	100% = 73	100% = 75	100% = 71

TABLE 14

Knowledge of Families in Contacts with Four Selected Agencies
Expressed as Percentage of Total Contacts Described in Each Group

	Children's Dept.	Welfare Dept.	Medico-Social Workers	Voluntary Organizations
Known to H.V. only	30·7	28·8	14·7	50·7
Known to agency only	2·7	4·1	25·3	—
Known to both	62·7	61·6	52·0	40·8
Known to neither	1·3	2·7	8·0	4·2
Not specified	2·7	2·8	—	4·3
Total	100% = 75	100% = 73	100% = 75	100% = 71

(a) *Contact with the Children's Department*

Seventy-five contacts were described. Two health visitors could not remember the last time when they had been in touch with the Children's Department, and one reply was incomplete.

Most of the contacts described were recent: 44·7% had occurred during the previous week and 82% within the previous month; in only four cases (5·3%) had the contact described occurred more than six months previously.

The initiator of the contact was usually (72·8%) the health visitor. It is significant that in answering this question, eighteen health visitors *spontaneously* remarked that they had *never* been contacted by anyone from the Children's Department and a further twelve spontaneously remarked on the poverty of communication with the Children's Department.

The method of communication most frequently recorded was the telephone (53·3%) followed by face to face contact (32%).

The family which was the subject of communication was usually (62·7%) known to both agencies. In a substantial minority (30·7%) of cases, however, the family was known to the health visitor only; the interpretation of this must be that the health visitor was performing the role of case-finder for the Children's Department and referring to them a family whose need might not otherwise have been discovered. In only two cases did the Children's Department refer to the health visitor a family which she did not already know.

Description of the content of the communication was too brief to analyse statistically, but the range covered was very wide. The biggest single group concerned general problems of problem families (nineteen cases); eleven were concerned specifically with fostering, nine with a child going into temporary care, six with promiscuous or pregnant teenagers, and three with suspected child cruelty or neglect.

(b) *Contact with the Welfare Department*

Seventy-three contacts were described. Four health visitors could not remember the last time when they were in touch with the Welfare Department, and one reply was incomplete.

Most of the contacts described were recent, 54·8% having occurred within the previous week, and 89% within the previous month.

As in contacts with the Children's Department the contact was usually (78·1%) initiated by the health visitor. Fourteen health visitors spontaneously remarked that they had never been contacted by the Welfare Department and a further two remarked on the poverty of communication with the Welfare Department.

The method of communication most frequently recorded (56·2%) was face to face contact; this may have been because in at least one area of the county the health visitors were based at the same premises as the Welfare Officers; 27·4% of the communications were made by telephone, and 11% by letter.

The family concerned was usually (61·6%) known to both agencies, but as in contacts with the Children's Department, a substantial minority (28·8%) of contacts were about families known previously only to the health visitor.

The subject matter of the communications covered a wide range. The largest single group (twenty-three cases) were concerned with the admission of elderly people to Old People's Homes. Eight were about other problems of the elderly, fourteen about physically handicapped people, eight about the mentally ill, and five about homeless families.

(c) *Contact with Hospital Medical Social Workers*

Seventy-five contacts were described. Three health visitors were unable to remember the last time they were in touch with a medical social worker.

As in contacts with the Children's and Welfare Department, the contacts described were usually very recent, 40% having occurred within the past week and 80% within the past month.

In contrast with the contacts with the Children's and Welfare Departments, contacts between health visitor and medical social worker were usually (72%) initiated by the medical social worker. Only one health visitor remarked that she had never been contacted by a medical social worker and only one remarked on poverty of communication.

The method of communication was usually (72%) the telephone, but a higher proportion (16%) of communications in this group were made by letter, and a much lower proportion (8%) by face to face contact. In 52% of the contacts described the family concerned was known to both agencies; this was less often than in the other two groups. This group differed also in that the medical social worker referred more new cases (nineteen cases) to the health visitor than did the health visitor to the medical social worker (eleven cases).

The subject of the communication was usually concerned in some way with a patient's hospital care, usually about services to be arranged and support required when a patient was discharged; in eighteen cases the medical social worker contacted the health visitor while the patient was still in hospital, in sixteen cases after the patient had been discharged; in six such cases the health visitor contacted the medical social worker. Other in-patients were discussed in eight cases and outpatients in six cases. In three cases the health visitor contacted the medical social worker about a patient soon to be admitted, and in two cases the medical social worker contacted the health visitor about patients who had failed to attend appointments.

(d) *Contacts with Voluntary Organizations*

Seventy-one contacts with a variety of organizations were described. The largest group of contacts described was with the W.R.V.S. (thirty-six cases); thirteen were with the British Red Cross Society, six with the Old People's Welfare Committee; other contacts described were with the Family Planning Association, specialist societies for the handicapped (e.g. Spastics Society, Society for Mentally Handicapped Children), local "good neighbour" schemes, local financial charities, and local church groups.

The contacts were usually very recent, 45·1% having occurred during the past week and 84·5% during the past month. The initiator of the contact was usually (83·1%) the health visitor, and, in contrast to contacts with other agencies, the family was more often known only to the health visitor (50·7%) than to both (40·8%). The method of communication most frequently recorded was the telephone, but a higher proportion (18·3%) than in any other group were by letter.

The subject of the communication was usually arrangements for a specific service which the particular organization provided. Twenty-

three were to arrange Meals on Wheels, twelve the provision of clothes, and ten were concerned with arrangements for recuperative holidays. These findings emphasize the role of the health visitor in the mobilization of resources to meet needs which are outside her own service.

5.3 *Meetings with Social Workers*

All respondents were asked whether they had any regular meetings with social workers, and if so to specify the form of meeting. Only twenty-three health visitors (29·5%) had any regular meetings with social workers, and these were almost all formal case conferences held at monthly or quarterly intervals.

5.4 *Conclusions*

Contact between the health visitor and other social agencies in Berkshire appeared to be frequent but, at least with the Children's Department and the Welfare Department, unsatisfactory from the health visitor's point of view. In particular the health visitors' complaint that communication was usually a one-way process (from the health visitor to the social worker) appeared to be substantiated. The high proportion of contacts with the Welfare and Children's Departments which were initiated by the health visitor would be reasonable if the health visitor was referring new cases for specialist help to the departments concerned, but that this was not so is shown by the high proportion of cases in which the family concerned was already known to both agencies. It is particularly disturbing that so many health visitors spontaneously remarked that they had never been contacted by these agencies whose clientele so obviously overlaps that of the health visitor. Since this study was undertaken, the Children's Department and the Welfare Department have become part of the new Social Services Departments which were set up by the Local Authority Social Services Act 1970. There is no evidence, however, that communication patterns in Berkshire have changed in any way.

The change of pattern in the initiation of the contacts between health visitor and medical social worker is interesting. The high proportion of visits which were initiated by the medical social worker might have been explained by the existence of the formal system of written communication between the hospital service and the local health authority which exists in Berkshire as part of the statutory responsibility for "after-care" laid upon the local health authority; the great majority of the contacts described, however, were made by telephone. It is also noteworthy that only one health visitor remarked that she had never been contacted by a medical social worker compared with fourteen who said they had never been contacted by the Welfare Department and eighteen who said they had never been contacted by the Children's Department. Perhaps the experience of hospital work and

membership of a medically orientated team provide a common ground between the health visitor and the hospital social worker which makes for greater mutual respect and understanding than exists between the health visitor and the local authority social worker. In 1974 responsibility for hospital and community health services (including the health visiting service) will be transferred to the new Area Health Authorities while social services will remain the responsibility of the local authorities. It is perhaps significant that hospital social workers themselves wish to remain within the health service while Social Service Departments would like to be responsible for all social work services with hospital social workers responsible to them but seconded to the health authority.

The lack of communication between different agencies who are working with the same family has been noted in other studies. Jefferys (1965) reported that in seventy-five families which were visited both by a health visitor and by another agency, in 40% the health visitor apparently did not know that another agency was involved, and in a further 35% the health visitor knew that another agency was involved but there was no contact between them.

A study by Donnison (1954) of the communications between various agencies involved in a sample of 118 families containing a neglected child was highly critical of the contribution made by health visitors and reported that health visitors referred few clients and had less discussion about clients than any other agency. He commented "The health visitors had very little contact with outside organizations. This isolation is a reflection of their absorption in the immediate problems of health; they need little help from other services in dealing with such problems."

The findings of this study, however, demonstrate quite clearly the key role of the health visitor in the network of social services.

CHAPTER 6

The Pattern of the Health Visitor's Visits

The central part of this study was a study of the home visit. For the purposes of the study, a visit was defined as by Akester and MacPhail (1963) in their study of health visiting in Leeds as "any contact with the public outside the clinic, surgery, or consulting room, resulting in advice, discussion, investigation, demonstration, or contact with another medical or social agency."

6.1 *Clientele*

In most accounts of the health visitor's clientele, a visit is recorded as a visit to a single "primary patient." Thus if a health visitor calls on a family following the notification of a new birth, the visit is recorded as a "visit to a child born in the current year." It may, however, and frequently does, happen that the birth has occurred in a family where there is another child under the age of five, and a schoolchild, and perhaps an elderly grandmother. If the health visitor already knows the family, she may decide that this is an opportune moment for a developmental assessment of the three-year-old in whom, perhaps, a problem was noted at the last visit some months ago, and for following up the health of the grandmother who was receiving treatment from the general practitioner; during the course of the visit the mother may ask advice about a problem associated with the schoolchild and discussion of this problem may occupy most of the visit. In the statistics prepared for the Department of Health and Social Security, such a visit might appear as a "visit to a child born in the current year" or as four separate visits. It was not possible to obtain a suitable cross-check for this study, but it is worthy of note that in a survey of the work of all nursing staff which was carried out for internal administrative purposes by Berkshire County Council in 1970, the number of visits made by health visitors during the survey period was recorded both by means of the survey forms (which recorded the total number of visits made), and by means of the normal statistical returns (which recorded the number of visits made to particular groups). The number of visits recorded in the survey forms was 8,545, whereas the number recorded in the statistical returns was 14,441.

To obviate this confusion, it was decided that in this study the composition of the household would be recorded in terms of "family types", but based upon the age groupings usually used in recording families by "primary patient." The categories used were:

1. Households where there was a child under the age of 1 year.
2. Households where there was a child aged 1–5 years (but no child under 1 year).
3. Households where there was a person over the age of 65 years but no child under the age of 5 years.
4. Households where there was neither a person aged over 65 years nor a child aged under 5 years.

The number of visits in each category is shown in Table 15. 71% of the visits recorded were made to households where there were young

TABLE 15

Type of Household visited by Health Visitors

Type of Household	Number	Percentage
Households containing child under 1 year	911	44·3
Households containing child 1–5 years but no child under 1 year	541	26·3
Households containing elderly person	370	18·0
Other households:	225	10·9
families with children 5–21 years.....106		
expectant mothers (with no other children).....12		
adults only (21–65 years).....78		
home helps (family composition not recorded)....18		
other 1		
Not specified	10	0·5
Total	2,057	100·0

children. The proportions recorded in most other studies are not directly comparable because they record visits to children rather than visits to households. It is interesting, however, that the statistical returns of the Department of Health and Social Security show that in 1968 "visits to children under 5 years" comprised 88·3% of all visits made by health visitors.

In the same returns the proportion of visits to the elderly was recorded as 9%; the proportion in this study was 18%. There is considerable variation in the proportions of visits to the elderly recorded in different studies; Jefferies (Buckinghamshire 1960) recorded a proportion of 5%, while at the other extreme Gilmore (Brighton 1969) recorded a proportion of 40·9%. Several studies have shown that the proportion of visits to the elderly recorded by health visitors attached to general practices is greater than the proportion recorded by non-attached health

visitors. The part played by the general practitioner in determining the health visitor's clientele is discussed in Chapter 10. The proportion in fact depends on a number of factors. The age structure of the population in a given area, the time of year, the employment in some areas of specialist geriatric health visitors are obvious factors; less obvious, perhaps, but equally important is the fact that because of the size of her caseload the health visitor selects whom she will visit and the priorities which she establishes depend as much on her personal interests and aptitudes as on external factors.

The 225 visits recorded to households where there was neither a young child nor an elderly person form a group which is of interest because it is inadequately recorded in official statistical returns. The group included a wide range of family situations, for example mothers expecting their first baby, families with schoolchildren, and handicapped adults.

The information collected concerning the occupation of the head of the household was too imprecise to be of use. The health visitor may not know the occupation of the head of household in the families whom she visits, and it would have been necessary to ask the question specifically for the purposes of the study. Since it was the aim of the study to record what normally happened, the information could have been obtained only by introducing into the interview subject matter which would not otherwise have been introduced. Jefferys suggested that "health visitors unlike most other social welfare staff, visited a fairly representative social cross section" (Jefferys 1965, p. 70).

Generally the health visitor was already known to the family whom she was visiting. In 69·6% of the visits recorded the health visitor had visited more than once before, and in a further 11·8% she had visited once before; 17·9% of visits were first visits.

6.2 *Purpose*

The purposes for which a health visitor may visit a family are complex and not easy to delineate. Unlike the nurse she does not visit in order to perform a clearly defined clinical service; unlike the social worker she does not visit in order to deal with a known problem. Jefferys (1965) reported "Generally speaking, visits were paid not because health visitors anticipated difficulties, but in order to see that all was well. Nearly 80% were described as routine calls or friendly visits, although once there, health visitors would often give advice on infant feeding or some other aspect of child-rearing." It is not always easy to isolate the purpose of the visit from the initiator of the visit (e.g. the request of a general practitioner to visit a family) and from what actually happened during the course of the visit.

In this study the purpose of the visit was the only "free" question used; the question asked was "What was the main purpose of your visit?" and the responses were later coded by the investigator. In spite of the two pilot studies which had been carried out it was found necessary

to change some of the categories which had been planned. The categories finally used and the number of visits coded in each category are shown in Table 16.

TABLE 16
Recorded Purpose of Home Visits

Recorded Purpose	Number	Percentage
Routine (child under 5 years)	521	25·3
Primary visit	156	7·6
Screening procedure	118	9·1
Arrangement of services	308	15·0
Physical health problem	63	3·1
General surveillance	132	6·4
Emotional support	157	7·6
Child management	200	9·7
Total assessment	106	5·2
Other	150	7·3
None (chance meeting)	55	2·7
Not specified	21	1·0
Total	2,057	100·0

For the purposes of this study a visit was recorded as "routine" where there was no reason for the visit other than the existence of a child under five years; in this category were included visits described by the health visitor as "birthday visit" or "routine check prior to starting school." The term "Primary Visit" is used to describe the first visit following the notification of the birth of a baby; "Screening" is used to describe those visits made for the purpose of carrying out the Phenistix test for the detection of phenylketonuria and the Stycar test for detection of deafness. Visits where the purpose was to deal with a problem of physical health care (e.g. a visit to advise a newly diagnosed diabetic about his diet) were distinguished from those made to deal with minor ailments of children (e.g. napkin rash) which were included in the category "child management." In the category "general surveillance" were included visits which were routine checks to families where there were no children aged under five years; typically the health visitor's description was "to see how Mrs. Jones was getting on." Visits were coded in the category "emotional support" only where this phrase was specifically used by the health visitor; it does not therefore include all visits where emotional support was part of the content of the visit. "Total assessment" was used where the purpose recorded by the health visitor was to assess the needs of the family and to advise or arrange whatever was necessary. The category "none" consisted of chance meetings which, because they included advice or discussion or exchange of information, fell within the definition of a "visit."

The visits coded "other purposes" covered a very wide range, from collecting the rent to dealing with attempted suicide.

The purposes recorded varied, as might have been expected, according to the type of household visited and the person or agency who initiated the visit. These factors are discussed later.

6.3 *Initiation*

The initiation of the home visit is a factor as complex as purpose, and is closely linked with it. The health visitor is an independent practitioner in her own right and she herself selects whom she will visit from her own caseload. She may, however, be asked by one of a number of agencies to visit a family whom she may or may not already know; she may receive requests from several agencies to visit one family, or she may have already intended to visit a family at the time when a particular request is received.

For the purpose of this study, the health visitor was asked to record the immediate initiator of the visit, i.e. a visit was recorded as initiated by the general practitioner if the health visitor would not have visited the family at the particular time had not the general practitioner requested her to do so.

The number and percentage of visits initiated by each agency is shown in Table 17. The proportion of visits which might be considered to have increased as a result of the policy of attachment, i.e. visits initiated by the general practitioner or by another member of the practice team is in fact higher than that recorded in studies carried out in other areas before the policy was implemented. Jameson (1956) recorded a proportion of 7% which included all sources other than the

TABLE 17

Sources of Home Visits

Source	Number	Percentage
Health visitor	1,306	63·5
Client	280	13·6
General practitioner	150	7·3
Other member of practice team	25	1·2
Other nursing/health visiting staff	29	1·4
M.O.H.'s department	38	1·8
Welfare department	12	0·6
Children's department	6	0·3
Hospital medical social worker	22	1·1
Voluntary agency	4	0·2
Other	46	2·2
None (chance meeting)	119	5·8
Not specified	20	1·0
Total	2,057	100·0

health visitor and the client, and Jefferys (1965) a proportion of 5% which included visits initiated by the general practitioner, the medical social worker, the district nurse, midwife, Children's Department and neighbours. The proportion recorded in this study is however much lower than in other studies of attached health visitors. For example the proportion of first visits (the proportion of total visits is not given) recorded by Gilmore (1970) as initiated by the general practitioner was 43·3% compared with 16·3% of first visits in the present study, and those initiated by another member of the practice team was 7·9% compared with 1·6% in this study.

Visits initiated by different agencies differed in the type of household visited, the purpose of the visit, and the length of the visit. Visits initiated by the health visitor were typically to households containing young children (77·4%), for a purpose associated with the young child (routine, primary visit, screening procedure and child management together comprised 64·2%), and lasted less than thirty minutes (82·3%). Visits initiated by the general practitioner were most commonly made to households where there were no young children (38·7% to elderly people and 22% to other age groups), for the purpose of arranging services (24%) or making a total assessment of the family situation (18·6%) and lasted rather longer (36% lasted more than thirty minutes). Visits initiated by other health personnel were most commonly to the elderly (40·2%) for the purpose of arranging services (46·7%) and lasted between fifteen and thirty minutes (47·8%). Visits initiated by social agencies (Children's Department, Welfare Department and medical social workers) were also most commonly made to the elderly (59·1%), for the purpose of arranging services (40·9%) and lasted between fifteen minutes and one hour (86·3%); it should be noted that the total number of visits in this group was small (2% of the total). Visits initiated by the client are discussed in greater detail in Chapter 9.

Just as the health visitor plays an important part in case-finding for other agencies, so other agencies, particularly the general practitioner, play an important part in case-finding for the health visitor. Thus 40% of the visits initiated by the general practitioners, were to households where the health visitor had not previously visited, compared with only 16·4% of visits initiated by the health visitor herself and 11·8% of visits initiated by clients.

6.4 *Planning, Duration and Subsequent Action*

The health visitor herself has final control over whom she visits, how much time she spends on each visit, and what action she takes subsequently. The present study was in no sense an analysis of how the health visitor spent her time, but health visitors were asked to record the approximate duration of each visit; they were also asked to specify whether or not a visit was planned in advance, and what subsequent action was taken.

Visits generally lasted less than thirty minutes; 28·4% lasted less than fifteen minutes, 50·9% lasted between fifteen and thirty minutes, 16·9% lasted between thirty minutes and one hour, and 3·4% lasted more than one hour.

Characteristics of very short and very long visits are shown in Table 18. Visits which lasted less than fifteen minutes were usually made to households containing young children (75·5%); the purposes most commonly described were routine visit to a child under five years (24·8%), arrangement of services (15·2%), and screening (12·5%); they were usually initiated either by the health visitor (62%) or by the client (12·2%). Visits which lasted longer than one hour included a smaller

TABLE 18

Characteristics of very short and very long Visits

	Visits Lasting		
	Less than 15 minutes (584 visits)	More than 1 hour (69 visits)	All visits (2,057 visits)
(a) *Type of household visited*			
Household containing young child	75·5	68·1	70·6
Household containing elderly person	14·4	10·2	18·0
"Other" households	9·1	21·7	10·9
Not specified	1·0	—	0·5
	100·0	100·0	100·0
(b) *Purpose*			
Routine visit to young child	24·8	8·7	25·3
Primary visit	4·8	1·5	7·6
Screening procedure	12·5	5·8	9·1
To arrange services	15·2	8·7	15·0
Physical health problems	3·3	4·3	3·1
General surveillance	4·8	8·7	6·4
Emotional support	4·3	23·2	7·6
Child management	11·6	7·2	9·7
Total assessment	1·7	7·2	5·2
Other	9·8	23·2	7·3
None (chance meeting)	6·3	—	2·7
Not specified	0·9	1·5	1·0
	100·0	100·0	100·0
(c) *Source of visit*			
Health visitor	61·9	33·3	63·5
Client	12·2	23·2	13·6
General practitioner	5·3	13·0	7·3
All other sources	20·6	30·5	15·6
	100·0	100·0	100·0

proportion of visits to households containing young children and a much greater proportion of visits to households where there was neither a young child nor an elderly person than in the very brief visits. The purposes most commonly described were to give emotional support (23·2%) and to assess the total situation (23·2%) although 8·7% were described as routine visits to a child under five years. A much lower proportion (33·3%) were initiated by the health visitor and a higher proportion were initiated by the general practitioner (13·0%) and by the client (23·2%) than in shorter visits.

Most of the visits (79%) were "planned", but a sizeable minority (19%) were "unintended" i.e. encountered by the health visitor by accident during the course of her work. The proportion of unplanned visits, although smaller than the 31·4% recorded by Akester and MacPhail (1963) indicates a difference in the way the health visitor works, when compared with other social welfare workers who normally visit only by appointment and with a well defined purpose in mind. It is a common occurrence for a health visitor, on returning to her car after completing one visit, to be greeted by several small children each bearing the message "My mum says can you pop in and see her while you're here." Those visits constitute an important part of the health visitor's work and may take up a considerable amount of time; more than half of them (56·3%) lasted longer than fifteen minutes and almost one in eight (12·4%) lasted longer than thirty minutes. Unplanned visits did not differ significantly in terms of clientele, purpose, initiation, or length from planned visits.

Action taken by the health visitor following the visit is shown in Table 19.

TABLE 19

Action Taken by Health Visitors following Home Visits

Action taken	Number	Percent
Arrangements for follow-up visit	796	38·7
H.V. contacted some other agency	332	15·7
Client advised to contact other agency	188	9·1
None (recorded only)	747	36·3
Not specified	4	0·2
Total	2,057	100·0

Contacts with other agencies are discussed in the following section. It is perhaps worthy of note that the majority of unplanned visits (56%) resulted in some subsequent action and the proportion involving contact by the health visitor with some other agency was slightly higher among unplanned visits (16·5%) than among planned visits (15·9%).

6.5 *Liaison with Other Agencies*

The problem of "multiple visiting", i.e. where several social agencies are visiting the same family has already been mentioned. Akester and MacPhail (1963) have pointed out that "theoretically, our existing laws could result in twenty-five or more visitors giving discordant advice." Such a situation is a disservice to the family whom all the agencies are trying to help, and is also a misuse of the time of scarce skilled personnel.

A considerable part of the value of the health visitor in the detection of health and social needs and the prevention of distress and family breakdown is due to the fact that she visits a great many families whom no-one else visits. In a substantial minority of the families with which she is in contact, however, she is not the only visitor, and in these families poor liaison between the agencies concerned may well result in conflicting advice and unnecessary duplication of effort.

The other agencies known to be currently visiting the families in the present sample is shown in Table 20; in some families more than one

TABLE 20

Visits to Households where Another Agency was known to be Currently Visiting

Agency currently visiting	Number	Percent
General practitioner	567	27·6
Midwife	64	3·1
District nurse	155	7·6
Welfare Department	85	4·1
Children's department	103	5·0
Other	212	10·3
No other agency known to be visiting	1,235	60·0

Note: Multiple answers possible; total exceeds 100%.

agency was known to be visiting. This list may not, however, be complete; health visitors do not always know that another agency is currently visiting the family. Jefferys (1965) reported that in seventy-five instances where other social welfare workers in the same study were known to have recently visited the families visited by health visitors, in 40% the health visitor had no knowledge of the visits of the other worker, and in a further 35% the health visitor knew of the visits of the other worker but there was no contact between them.

Following 322 (15·7%) of the visits in this study the health visitor contacted some other agency. The agencies contacted are shown in Table 21 and 21*a*.

The percentage varied according to the type of household visited. In 9·9% of visits to households containing young children the health

TABLE 21

Agencies contacted by Health Visitors after Home Visits

Agencies Contacted	Number of Instances
General practitioner	77
Other member of practice team	17
Hospital services	20
Local authority health services	72
Other local authority services (Housing, Welfare, Children's Education)	76
Other statutory services (Ministry of Social Security, Probation service, D.R.O.)	18
Voluntary organizations	54
Day care of children (playgroup, child minder, nursery school)	7
Other	21

TABLE 21a

Social Work Agencies included in Table 21

	Number of Instances
Medical social worker	9
Psychiatric social worker	1
Blind welfare worker	1
Moral welfare worker	4
Probation officer	6
Welfare officer	36
Child care officer	17
Child guidance clinic	5
Unspecified social worker	2

visitor subsequently contacted another agency; in visits to the elderly the proportion was 33·5%; and in visits to other households it was 24·4%. These figures, particularly in relation to the elderly and "other" age groups, are an indication of the importance of the health visitor as a case-finder for other services.

A further indication is given by an analysis of the original purposes of those visits which were followed by contact with other agencies. This analysis is shown in Table 22. It is interesting that such contact was made in more than one in five of the visits where the purpose was merely "a watching brief" and after almost one in ten of chance meetings.

When the health visitor knew that another agency was visiting the family was there duplication of effort? Did the health visitor contact the agency after the visit? When the visit was initiated by another agency did the health visitor report back? Answers to some of these questions can be suggested by the results of an analysis of visits involving the Welfare Department and the Children's Department; the answers are

TABLE 22

Original purposes of Visits which resulted in Contact with another Agency

Original purpose	Total number of visits made for this purpose	Number of visits resulting in contact	Percentage of visits resulting in contact
Routine, primary visit, screening	865	44	5·1
Arrangement of services	308	109	35·4
Physical health problem	63	22	35·0
General surveillance	132	28	21·2
Emotional support	157	32	20·4
Child management	200	13	6·5
Total assessment	106	41	38·7
Other	150	26	17·3
None (chance meeting)	55	5	9·1
Not specified	21	2	—
Total	2,057	322	

however only partial because individual agencies contacted as part of the health visitor's subsequent action cannot (because of the form in which the data were transferred to punch cards for analysis by computer) be readily identified.

Of the eighty-five visits where the Welfare Department was known to be currently visiting the family, all but three were to families which the health visitor had visited before. Forty-three were initiated by the health visitor, ten by the client, nine by the general practitioner, five by other health agencies, seven by the Welfare Department, two by voluntary organizations, four by other people, and four were chance meetings. Twenty-two of the visits were made in order to arrange services, a further twenty were for general surveillance, and a further twelve were to make an assessment of the total situation—a total of fifty-four visits where the purpose was one which, it could be argued, could have been carried out by either the health visitor or the Welfare Officer. Of the twelve visits initiated by the Welfare Department itself (i.e. including five where the Welfare Officer was not thought to have visited the family himself) nine were to arrange for other services (probably the provision of a home help). Twenty of the eighty-five visits lasted longer than half-an-hour, and three lasted longer than an hour. The health visitor subsequently contacted another agency (possibly but not necessarily the Welfare Department) after thirty-eight of the visits and advised the client to contact another agency after a further nine visits.

Of the 103 visits made to families where a Child Care Officer was known to be visiting all but four were to families which the health visitor had visited before. Sixty-two of the visits were initiated by the health visitor, sixteen by the client, six by the general practitioner,

three by the Medical Officer of Health's department, five by the Children's Department, five by other people, and six were chance meetings. They included seventeen visits made for the purpose of assessing the total situation and twelve for general surveillance. Of the six visits initiated by the Children's Department (i.e. including one where no Child Care Officer was actually visiting) two were for routine checks on a child under five years, one was to deal with a physical health problem, and three were for other purposes. Forty-one of the 103 visits lasted longer than half-an-hour and ten lasted more than an hour. Following twenty-six visits the health visitor contacted another agency (possibly but not necessarily the Children's Department) and the client was advised to contact another agency following a further eight visits.

These statistics cannot give an exact picture of the visits to which they refer, but they do suggest that in these visits there was possibly duplication of services and considerable expenditure of time.

6.6 *Summary*

This analysis of the pattern of the health visitor's home visits may best be summarized by describing and comparing the visits made to each of the three main types of household.

Most of the visits (70·6%) were to households where there was a child under the age of five years; in approximately two out of three of these households there was a baby under the age of one year. In most of (72·2%) the visits the health visitor already knew the family because she had visited more than once before. The purpose of the visit was usually associated with the existence in the household of the young child; the purpose most commonly described (36·1%) was a routine check on the young child, 10·9% were primary visits following the notification of birth, 13·1% were for the purpose of carrying out a screening procedure, and 12·7% were to deal with a specific problem of child management. In most of the families (72·1%) the health visitor was thought to be the only social welfare worker visiting, but in 6·3% a Child Care Officer was also visiting. Most of the visits (69·7%) were initiated by the health visitor herself, but 14·1% were initiated by the client and 4·0% by the general practitioner. The visits were usually planned in advance (83%) and were usually relatively short in duration, 30% lasting less than fifteen minutes although a small number (3·2%) lasted more than an hour. Following the visit the health visitor usually took no action other than to record the visit or to make arrangements for a follow up visit.

About one in five of all visits (18%) were made to the elderly. The family was usually (69·5%) already known to the health visitor although slightly less frequently than in visits to households containing young children. The purposes most commonly recorded in these visits were to arrange services (41·4%) and general surveillance (24·1%). The family was usually being visited also by at least one other agency: 60% were

visited by the general practitioner, 32·2% by the district nurse, and 11·3% by the Welfare Department. The visit was not usually initiated by the health visitor although she initiated a higher proportion of the visits (49·7%) than any other single agency; 15·7% were initiated by the general practitioner, 8·4% by the client. The visits were usually planned and tended to last longer than visits made to households containing young children; 21·9% lasted longer than half-an-hour, but less than 2% lasted longer than an hour. Following one-third of these visits (33·5%) the health visitor contacted some other agency and following a further third (33·0%) she made arrangements for a follow-up visit.

Approximately 11% of the health visitor's visits were to households where there was neither a young child nor an elderly person; this group included a wide variety of family situations. The family was less likely to be already known to the health visitor (61·3%) than among other groups. The purpose most commonly recorded was to arrange services (30·7%) but a wide variety of purposes was recorded, 19·6% being included in the category "other." In 45·3% of visits the health visitor was thought to be the only visitor; the general practitioner was the most likely additional visitor (41·3%). The visits were usually planned and tended to be of longer duration than visits to households containing young children; 28% lasted longer than half-an-hour and 6·7% longer than an hour. Following a quarter of these visits (24·4%) the health visitor contacted some other agency, and in a further third (33·3%) she made arrangements for a further visit.

CHAPTER 7

The Content of the Home Visit

7.1 *Methodological Considerations*

Health appraisal, health teaching, providing emotional support, and social counselling—the expressed aims of the home visit—can be successfully accomplished only through communication with the client. The verbal behaviour of health visitors and their clients in face-to-face contact in the home visit is the major, though not the only, component in such communication. Verbal behaviour may be classified according to the subject matter discussed, the time devoted to each item, the relative contribution of participants, the mechanisms of communication (questioning, advising etc.), the expressions of affect (especially anxiety or hostility) forms of reassurance, instances of laughter and of silence.

Reference has already been made to Johnson and Hardin's study of the verbal behaviour of a sample of 157 American public health nurses and their clients in 287 home visits. They devised a series of specific indices for measuring various dimensions of verbal involvement. The dimensions considered were the subject matter, the dominance of the nurse, the teaching and health counselling component, the affective (emotional) component, and the problem orientation.

The present study considers three dimensions of the verbal behaviour of health visitors and clients in the home visit—subject matter, the initiation of subject matter, and the "level of verbal involvement" of the health visitor. The second and third of these are considered in Chapters 8 and 9.

The general significance of examining subject matter in verbal behaviour is obvious. A knowledge of content provides a valuable tool for the evaluation of relevance in the trends of verbal interaction, and is the basis for a general estimation of current levels of care in the light of client needs. In the context of this study it would suggest answers to questions such as "To what extent do the topics of interaction coincide with the purposes for which the health visitor has entered the household?" "What effect do personal characteristics of the health visitor, such as age or marital status, have upon the content of her work?" "What is the effect of external variables, such as the existence of another agency visiting the family?" "To what extent does the health visitor follow some hypothetical agenda based on a model or framework of

subject matter appropriate for the particular purposes and circumstances in which the health visitor visits?"

Topics concerned with physical health	Topics concerned with emotional or mental health	Topics concerned with social care
Diet (all age groups)	Mental and emotional development	Daily minding/ day nursery
Physical development	Emotional or behaviour problem (all age groups)	Playgroup/nursery school
Immunization	Mental illness (frank or latent)	Fostering/ adoption
Screening procedure	Mental subnormality	Child cruelty/ neglect
Minor ailments (all age groups)	Mental wellbeing of ante-natal mother	Preparation for school
Specific illness/defect/ disability	Mental wellbeing of post-natal mother	School
General health (of other members of family)	Adjustment to illness/ handicap/disability	Employment
General hygiene	Adjustment to recent marriage	Financial inadequacy
Physical health of ante-natal mother	Marital disharmony	Social security benefits
Physical health of post-natal mother	Adjustment to/ preparation for retirement	Legal problem
Nursing care	Bereavement	Household Management
Family planning		Home help
Menopause		Home safety
Other health topic		Other (non-health) topics

Note

(a) Topic No. 15 (other topic concerned with child under five years) was omitted from this classification.

(b) Topic No. 50 (relationship building) was omitted in analysis of all groups.

The method of presenting the subject matter of the home visit as recorded in the visit schedules will be to show how often particular topics occur in the 2,057 home visits recorded, and in various subgroups within the total sample. The frequency, expressed as a percentage of the total number of visits within the group, is referred to as a "topic incidence." Topics were further grouped into larger classification units related to those aspects of the stereotype of health visiting which the study was attempting to test, i.e. topics specifically concerned with the care of children under five and those not specifically concerned with children under five, topics concerned with physical health care, those concerned with mental or emotional health care, and those concerned with "social care." Topics specifically concerned with children under five years were grouped under that heading on the visit schedule (see Appendix); the group to which each of the fifty-one topics was assigned in the second classification is shown opposite.

Such divisions must inevitably be arbitrary. Family planning, for example, could have been placed under any of the three headings; it involves both physical and mental health care, and it could have been grouped under "services provided" which were included in "social care" topics.

There are other limitations in this method of presenting the subject matter of the visit. A more serious difficulty inherent in the use of the "topic incidence" as a measure of content is that it takes no account of the time spent in discussion of various topics nor, therefore, of the relative importance of each topic within the discussion. The unstructured interview, like normal conversation, tends to move along an erratic and unpredictable course as far as the flow of ideas is concerned; ideas are introduced and not pursued, re-introduced, mentioned in passing or discussed at length. For the purposes of the visit schedule, if a topic occurred once within a visit it was counted as an "occurrence", whether it was merely mentioned in passing or discussed at length. Consideration of other dimensions of the verbal interaction are discussed later; at this point attention is confined simply to the presence or absence of topics.

7.2 *General Survey of Content*

The incidence of each topic in the total sample of visits is shown in Figure 1.* Every topic listed occurred, but no topic occurred in more than 40% of the visits. The topic mentioned least often (the menopause) occurred fourteen times, an incidence of 0·7%; the topic most often mentioned (infant feeding) occurred 756 times, an incidence of 36·8%; 165 different topics were specified under "other" but only three of these

* The original topic number 50, 'Relationship building', was excluded from Figure 1 and subsequent similar figures as it was not appropriate for analysis.

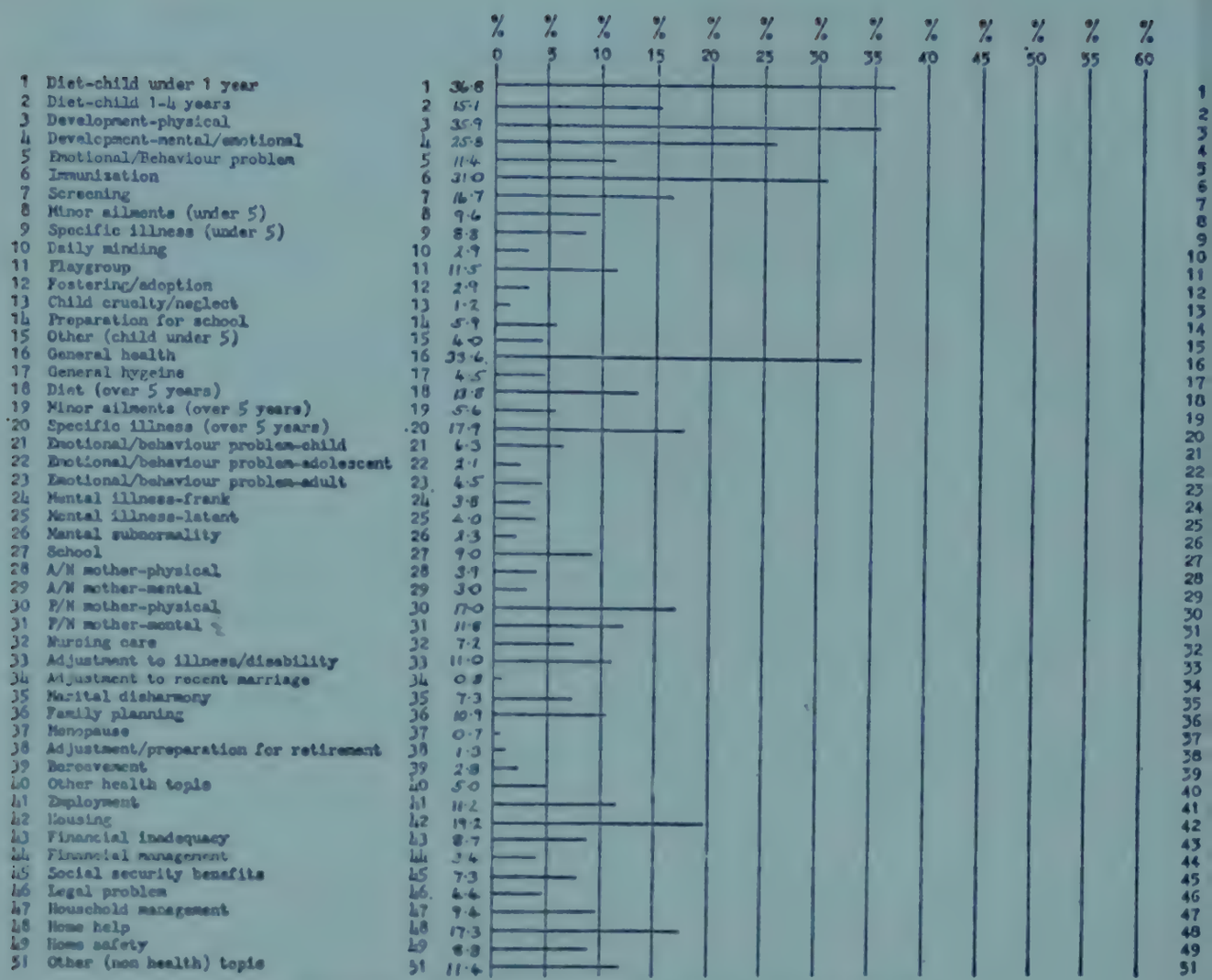

Fig. 1. INCIDENCE OF TOPICS RECORDED IN HOME VISITS (ALL VISITS)

were mentioned as often as the listed topic with the lowest incidence; these were holidays (fifty-seven occurrences, an incidence of 1·8%), aids for handicapped people (thirty-six occurrences, an incidence of 1·75%), and Meals on Wheels services (fourteen occurrences, an incidence of 0·7%). Assuming that a full-time health visitor will make approximately thirty visits each week (the mean number of schedules per full-time health visitor in this study was thirty) it can be estimated that any topic with an incidence greater than 5·3% is likely to be discussed by a health visitor during a home visit at least once a week; topics listed but likely to be discussed less often than once a week were daily minding, fostering or adoption, behaviour problems of adolescents, mental subnormality, and bereavement (all of which might be expected to be discussed about once a fortnight), and child cruelty, adjustment to recent marriage, and the menopause (all of which might be expected to be discussed about once a month).

The wide range of topics recorded and the relatively low incidence of the topics most frequently recorded are indications of the tremendous variety in the subject matter discussed by health visitors and their clients in home visits.

Topics not specifically concerned with young children were recorded

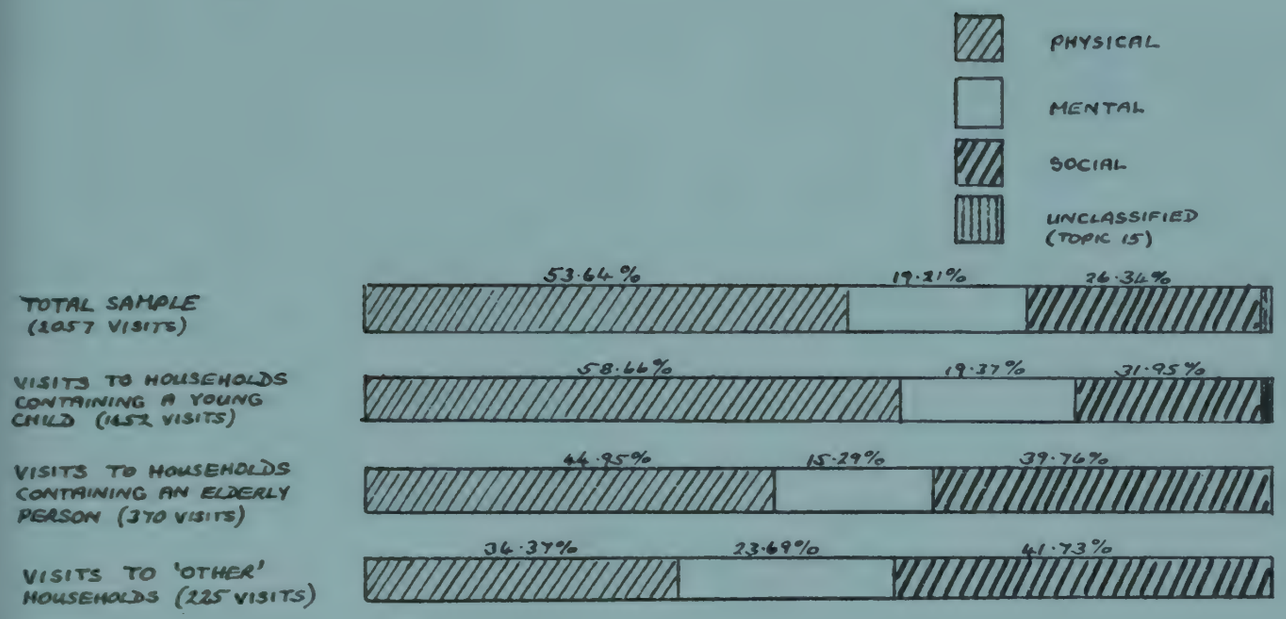

Fig. 2- RELATIVE PROPORTION OF TOPICS CONCERNED WITH PHYSICAL HEALTH CARE, MENTAL HEALTH CARE, AND SOCIAL CARE

in 80·3% of all visits, and in 73·6% of the 1,069 visits made to households containing young children. Although infant feeding, physical development of young children, and immunization were among the topics most frequently recorded they were discussed in only approximately one-third of all visits. Topics specifically concerned with young children comprised less than half (43%) of all occurrences recorded, and even when visits to households where there was no child under the age of five years were excluded from the analysis, the proportion was only 55·6% (Figure 3).

When topics were grouped into those concerned with physical health, those concerned with mental health, and "other" or "social care" topics, "mental health" topics were recorded in 59·1% of all visits, and "social care" topics in 65·8% of all visits. "Mental health" topics made up 19·2% of all topics recorded; "social care" topics made up 26·3%

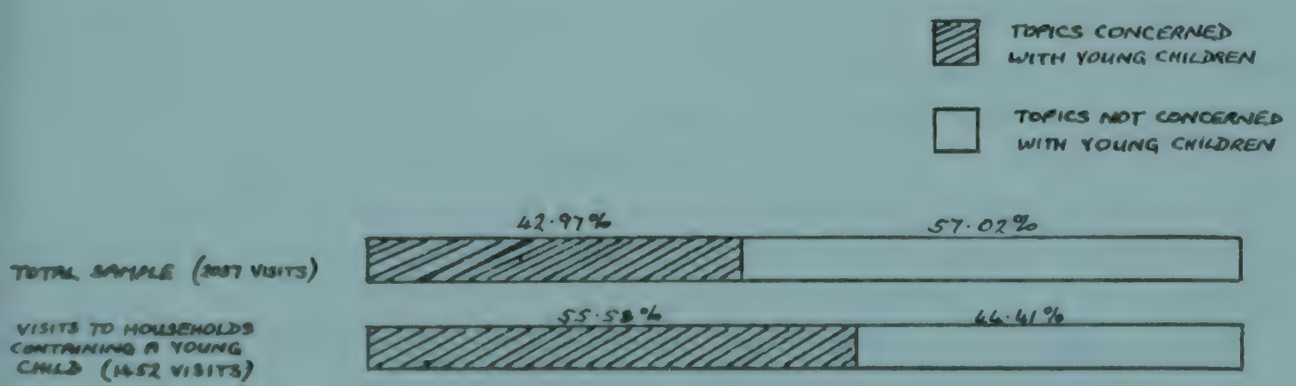

Fig. 3- RELATIVE PROPORTION OF TOPICS CONCERNED WITH YOUNG CHILDREN

of all topics recorded (Figure 2). The relative proportion of both "mental health" and "social care" topics was increased in visits to households where there was neither a young child nor an elderly person, in visits which lasted longer than one hour, and in visits initiated by general practitioners. The relative proportion of "social care" topics was also increased in visits to households containing an elderly person, and was higher in visits to families where a social worker was known to be currently visiting.

7.3 *Content of Visits*

(a) *Visits to families with Young Children*

Most of the health visitor's visits (70·6%) were made to families where there were young children. "Maternity and child welfare" traditionally has been and clearly still is the major part of the health visitor's work. The controversy arises, however, in the interpretation of this term. On the one hand some assert that this work was and is no more than advice to expectant mothers and mothers with young children about matters affecting their physical welfare together with reassurance to relieve the natural anxieties of mothers about their health or their children's physical development; this is the interpretation which is embodied in the stereotype previously described. On the other hand some assert that "maternity and child welfare" embraces all activities that may be undertaken on the occasion of visits to mothers and their children, thus including in the term all the psychological and socio-economic factors which have a bearing on the lives of families where there happen to be young children. An analysis of the content of the sub-group of 1,452 visits made to households containing a child under the age of five years yields considerable information about how far the health visitor's work extends towards the wider definition.

The incidence of each topic in this group of visits is shown in Figure 4. The topics most often recorded were infant feeding (51·9%), physical development (50·3%), immunization (43·7%), mental and emotional development (36%) and the general health of other members of the family. Only one topic—preparation for retirement—was not recorded at all. Two other topics—adjustment to recent marriage, and the menopause—were recorded in less than 1% of the schedules.

Topics not specifically concerned with young children were recorded in 73·6% of these visits and comprised 44·4% of all topics recorded (Figure 3).

In the subgroup of 865 visits where the purpose of the visit recorded was a routine visit to a young child, a "primary" visit to a new baby, or to carry out a screening procedure, i.e., where the purpose of the visit was directly related to the presence of a young child, the proportion of topic occurrences not specifically concerned with young children, while

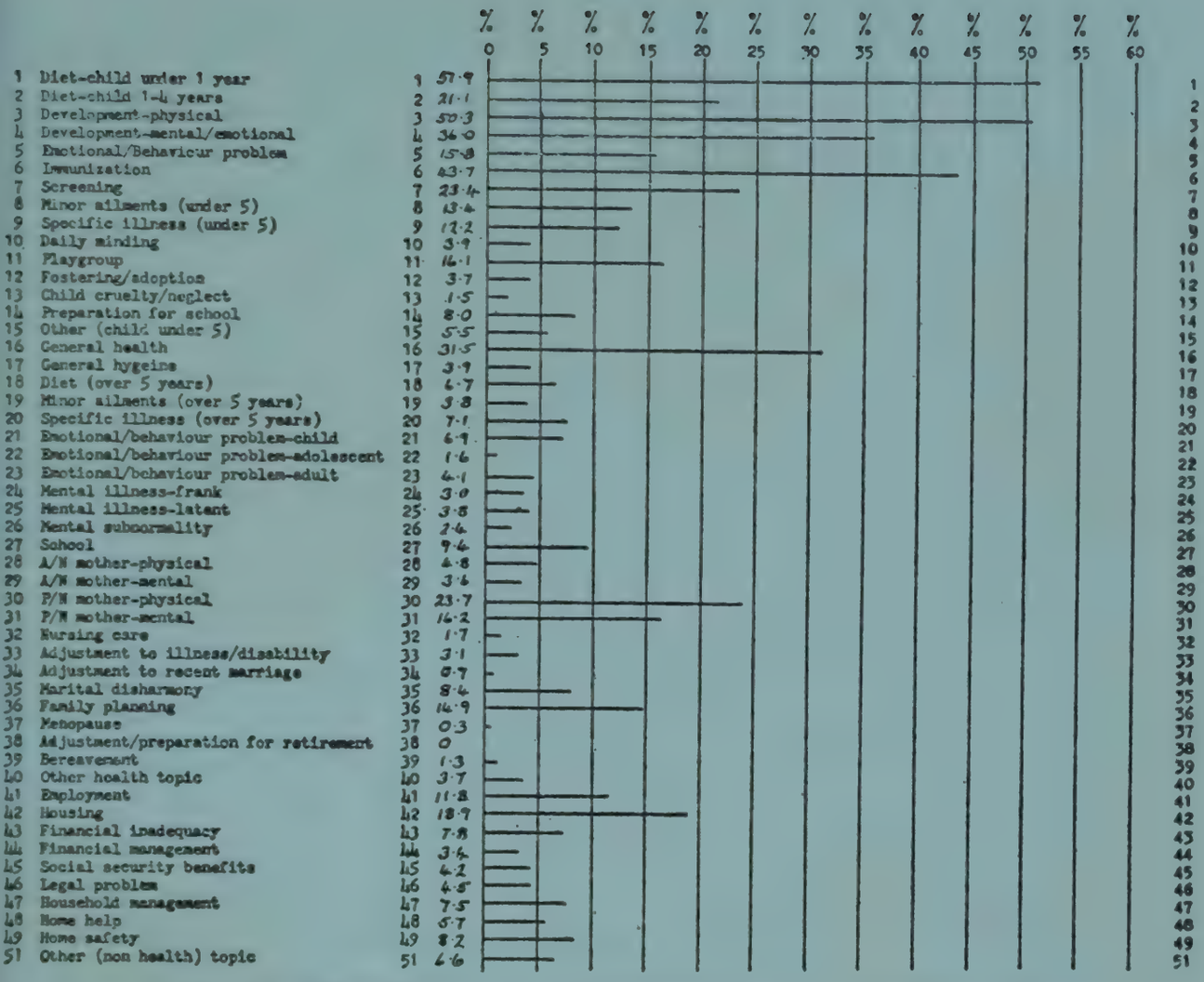

Fig. 4. INCIDENCE OF TOPICS RECORDED IN VISITS TO HOUSEHOLDS CONTAINING A CHILD UNDER 5 YRS (1972 VISITS)

lower than in the main group, nevertheless comprised nearly 40% (39·9%) of all topics recorded.

This appears to confirm the view that the young child is the "way in" to the family situation rather than the only, or even the main, object of the health visitor's attention, and that the home visit is family-orientated rather than child-orientated even though the visit is officially recorded as a visit to a child born in a particular year. It is noteworthy, for example, that emotional or behaviour problems of older children were recorded in one hundred (6·9%) of these visits, and of adolescents in twenty-three (1·6%) visits, diet other than that of the young child in ninety-seven (6·7%) visits, and a specific illness of someone other than a young child in 103 (7·1%) visits. A higher proportion of these topics (42·8%) was introduced by the client than of the topics specifically concerned with young children (38·5%).

It is sometimes suggested that the health visitor makes a particularly valuable contribution to the prevention of family breakdown by detecting early signs of stress in a family and helping to relieve such stress before break-down point is reached. It is therefore interesting to note the frequency with which marital disharmony (122 occurrences, an incidence of 8·4%) and mental illness (ninety-eight occurrences, an incidence of 6·8%) were recorded in this group of visits. Moreover the topics were recorded only when they occurred in verbal exchange

between health visitor and client; occasions where the health visitor might have noted the existence of these stresses in the family and might have decided to make a return visit, or taken some other action, but did not mention the subject during the visit were not included.

The proportion of "physical health care" topics was 58·7%, "mental health" topics 19·4%, and "social care" topics 22% (Figure 2). This is a higher proportion of "physical health" topics and a lower proportion of "social care" topics than in visits to other groups; the proportion of "mental health" topics was about the same as in the total sample.

Visits to families containing young children constitute the only group of visits where topics concerned with physical health care comprised more than half the total topics recorded, but the evidence suggests that greater emphasis is placed on physical health care than on other aspects. The physical development of young children was recorded more frequently (730 occurrences, an incidence of 50·3%) than was their mental and emotional development (522 occurrences, an incidence of 36·0%). The physical health of the post-natal mother was recorded more frequently (344 occurrences an incidence of 23·7%) than was her mental and social well-being (235 occurrences, an incidence of 16·2%).

Topics not concerned with physical health care, do, however, comprise a substantial proportion (41·3%) of the total. Of particular interest is the proportion of "social care" topics (22%), since this group includes many topics which it is not generally considered part of the health visitor's function to discuss. Housing was recorded in almost one in five of these visits (275 occurrences, an incidence of 18·9%); this would not be surprising if the study had been carried out in the centre of a large conurbation with a recognized housing problem, but it is noteworthy in an area where the housing problem is less severe than in many other areas. Employment was recorded in almost one in eight of these visits (171 occurrences, an incidence of 11·8%), and a legal problem in about one in twenty (sixty-five occurrences, an incidence of 4·5%).

How far the client was responsible for the introduction of these topics, and to what extent the health visitor advised upon them are considered in Chapter 9. "Maternity and child welfare" work includes clinic work as well as home visiting, and clinic work was not considered in this study, but if "maternity and child welfare visits" are taken to mean visits to households which contain a child under the age of five years, this analysis suggests that the work of the health visitor in maternity and child welfare approximates more closely to the wider interpretation of the term than to the limited interpretation which is embodied in the stereotype.

(b) *Visits to the Elderly*

Visits to the elderly constitute a rapidly expanding part of the health visitor's work. In this study 370 visits were recorded to households

containing a person over the age of sixty-five, a proportion of 18% of the total visits recorded.

The frequency with which each topic was discussed in this group of visits is shown in Figure 5. The "topic pattern" is, not unnaturally, quite different from that of the visits to households containing young children.

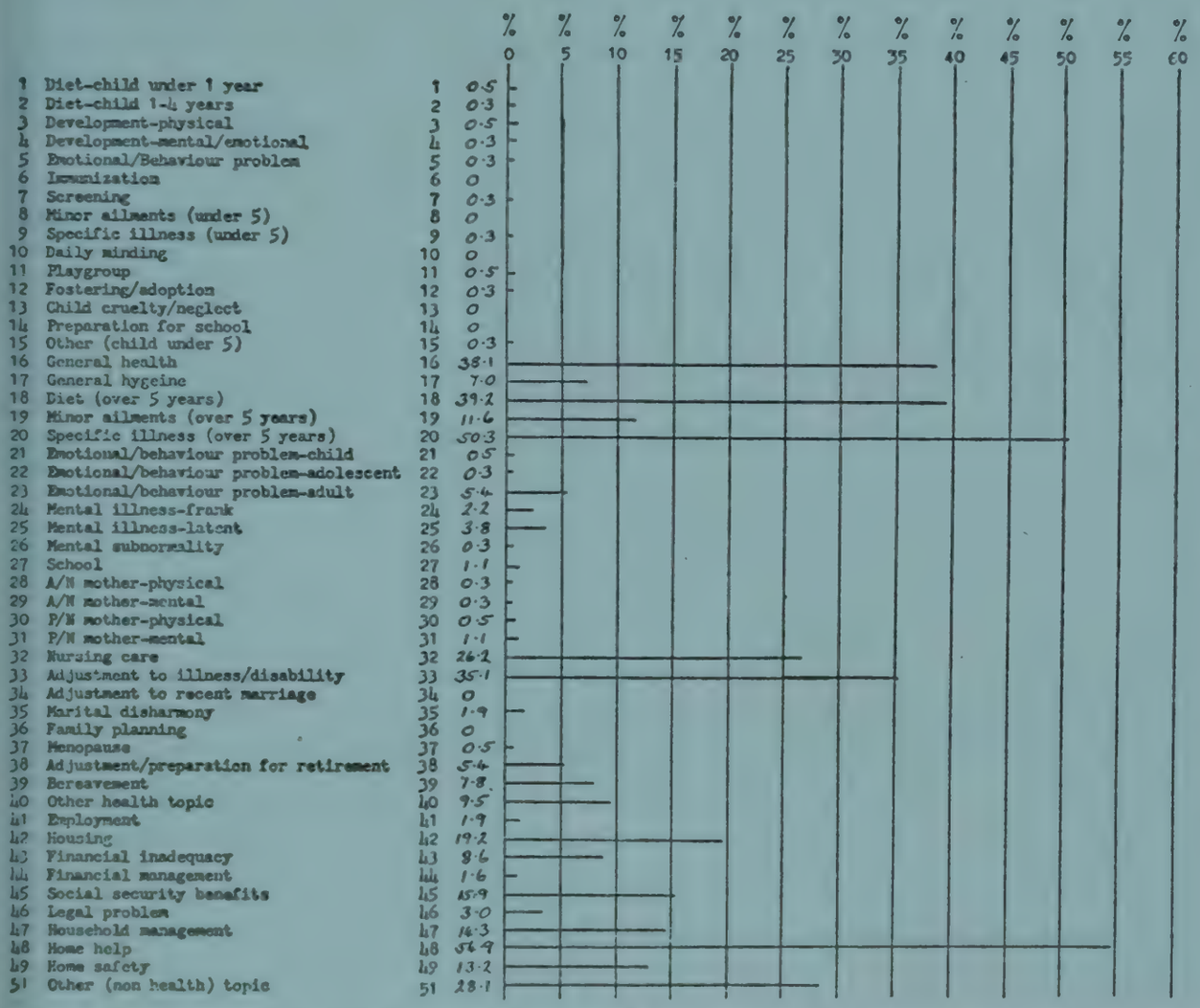

Fig. 5. INCIDENCE OF TOPICS RECORDED IN VISITS TO HOUSEHOLDS CONTAINING AN ELDERLY PERSON (370 VISITS)

The topics most frequently recorded were home help (203 occurrences, an incidence of 54·9%), specific illness or disability (186 occurrences, an incidence of 50·3%), diet (145 occurrences, an incidence of 39·2%), general health (141 occurrences, an incidence of 38·1%), and adjustment to illness, handicap, or disability (130 occurrences, an incidence of 55·1%). The incidence of all these topics, with the exception of general health, is far higher than in visits to other groups. Other topics which were recorded far more frequently in this group of visits than in the total sample were nursing care (ninety-seven occurrences, an incidence of 26·2%), bereavement (twenty-nine occurrences, an incidence of 7·8%) social security benefits (fifty-nine occurrences, an incidence of 15·9%), and home safety (forty-nine occurrences, an incidence of 13·2%).

The proportion of topic occurrences concerned with physical health was 45%, with mental health 15·3%, and with social care 39·7% (Figure 2). This is a higher proportion of occurrences concerned with

"social care" and a lower proportion concerned with "physical health care" than in the sample as a whole; the proportion of occurrences concerned with "mental health care" was slightly lower than in the sample as a whole.

The relatively low occurrence of physical and mental health topics among the elderly is interesting. "Social care" topics were discussed in 85·6% of visits to the elderly, a higher proportion than in visits to other groups. The frequency with which social security benefits were recorded (15·9%) was more than double that in the total sample (7·3%), and the frequency with which home help was recorded (54·9%) was more than treble that in the total sample 17·3%).

Other social services for the elderly were recorded under the heading "other"; these included clubs for the elderly (six occurrences), holidays (thirty-seven occurrences), Meals on Wheels (fourteen occurrences), aids (thirty-six occurrences), and chiropody (eight occurrences).

In view of the fact that home help is one of the services which as a result of the Local Authority Social Services Act has been transferred from the Health Department to the Social Services Department, it is noteworthy that the most frequently recorded topic of conversation between health visitors and the elderly was home help.

Only a third (34·4%) of "social care" topics were introduced by the client, a proportion lower than in visits to other groups, although the overall proportion of "social care" topics was higher. This suggests that the health visitor is aware of, and does indeed consider the social needs of the elderly in spite of the assertion made by the Seebohm Committee that "Greater emphasis in the training of health visitors ought to be given to the medico-social needs of old age and how these might be met, and more training about these will be necessary for many at present in post."

(c) *Visits to Other Households*

Visits to households where there is neither a young child nor an elderly person have not traditionally been recognized as part of the health visitor's work.

The number of such visits, however, has been growing in recent years, and it has been suggested that this area expands rapidly where health visitors work within general medical practice.

In the present study 225 visits to households where there was neither a young child nor an elderly person were recorded, a proportion of 10·9%. The frequency with which topics were recorded in these visits is shown in Figure 6. The topic pattern is different from that of visits to other groups.

The topics most frequently recorded in these visits were general health (ninety-two occurrences, an incidence of 40·9%), specific illness or disability (seventy-nine occurrences, an incidence of 35·1%), home help

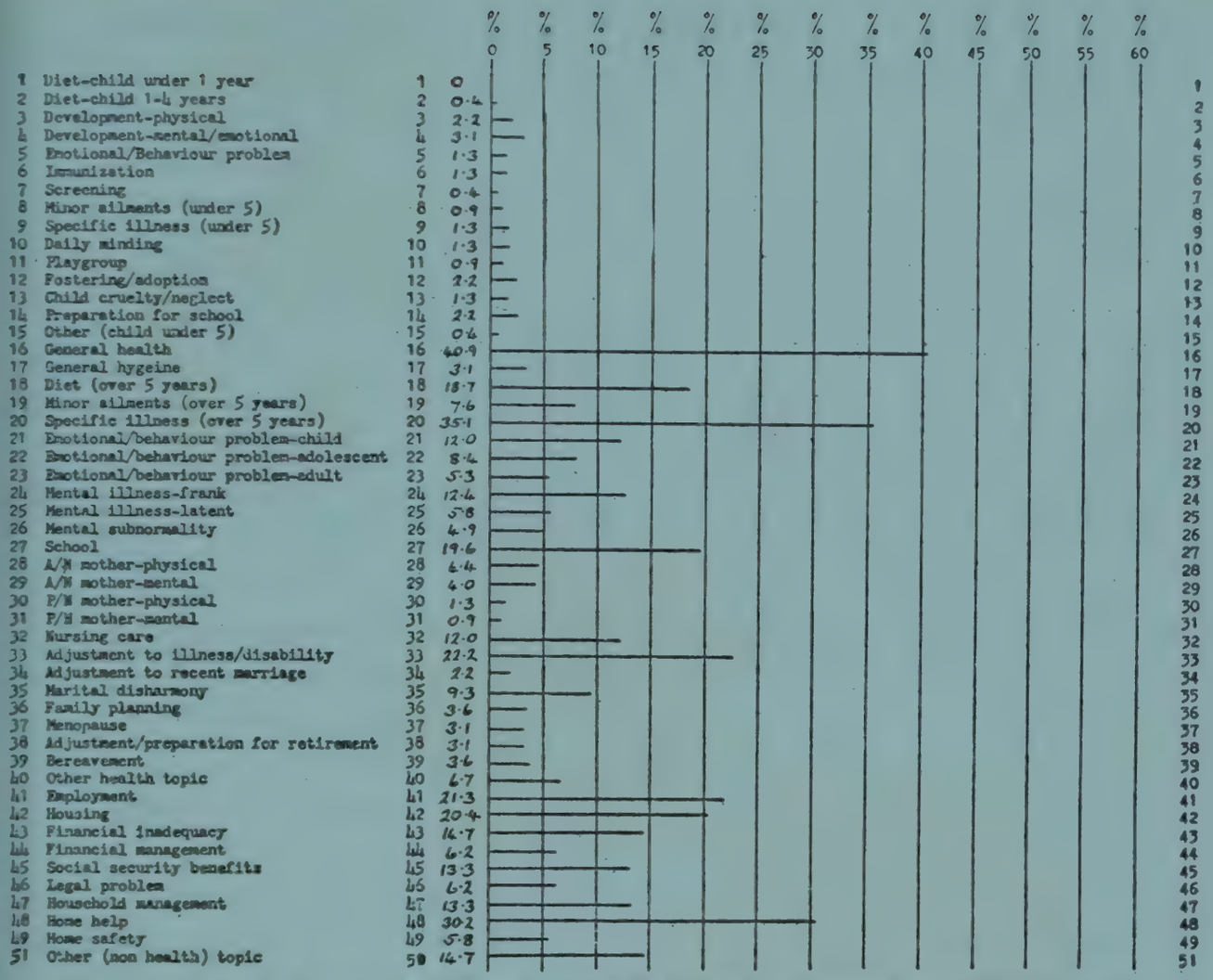

Fig. 6. INCIDENCE OF TOPICS RECORDED IN VISITS TO 'OTHER' HOUSEHOLDS (225 VISITS)

(sixty-eight occurrences, an incidence of 30·2%), adjustment to illness, handicap, or disability (fifty occurrences, an incidence of 22·9%), and employment (forth-eight occurrences, an incidence of 21·3%). Other topics whose incidence was much greater than in the total sample were emotional problems of adolescents (nineteen occurrences, an incidence of 8·4%), mental illness (twenty-eight occurrences, an incidence of 12·4%), financial inadequacy (thirty-three occurrences, an incidence of 14·7%), and social security benefits (thirty occurrences, an incidence of 13·3%). The topics most frequently introduced by clients in these visits were specific illness or disability (forty-one occurrences), employment and general health (twenty-eight occurrences), financial inadequacy (twenty-six occurrences) and housing (twenty-five occurrences).

Although the two topics most frequently recorded overall in these visits were concerned with physical health, the proportion of occurrences concerned with physical health care was smaller, and the proportions concerned with mental health and social care were much greater than in the total sample. Topics concerned with physical health care comprised 34·4% of all occurrences, with mental health 23·7% of all occurrences, and with social care 41·7%. Mental health topics occurred in 60·4% of those visits and social care topics in 83·6%.

A higher proportion (50·4%) of topics in these visits was introduced by the client than in the total sample (40%), as was a higher proportion

of the topics concerned with social care (36·4%) and of topics concerned with mental health (45·2%) than of those concerned with physical health (29·5%).

7.4 *The Relationship of Content to the Purpose of the Visit*

It is frequently suggested that the value of the health visitor's work in the prevention of ill-health and family breakdown lies in the fact that health visitors visit families where no problem is apparent, and that during the course of these visits they are able to detect and to deal with difficulties in their early stages.

In an attempt to discover whether this suggestion could be confirmed or disproved, the subject matter of the 865 visits in which the purpose of the visit was recorded as "routine visit to a young child", "primary visit", or "screening procedure" was analysed. These three purposes were specifically associated with the presence in the family of a young child, and implied that the health visitor did not anticipate any particular problem (as opposed to visits where the purpose was described as "to give emotional support" or "to deal with a health problem or a problem of child management", or "to arrange the provision of other services").

In these visits the topics most frequently recorded were, not surprisingly, infant feeding (553 occurrences, an incidence of 63·9%), physical development (474 occurrences, an incidence of 54·8%), immunization (466 occurrences, an incidence of 53·9%), and mental and emotional development (323 occurrences, an incidence of 37·3%). But although the prime focus of the visit was the young child, 40% of all the topics recorded were not concerned with young children. The general health of other members of the family was recorded 272 times (an incidence of 31·4%) and housing 158 times (an incidence of 18·3%). On thirty occasions (3·5%) the client introduced the emotional/behaviour problems of a child aged over five years, and on ten occasions (1·2%) the behaviour problems of adolescents. On twenty-two occasions (2·5%) the client initiated discussion of a marital problem, and on sixty-five occasions (7·5%) family planning. Other general problems frequently raised by the client were housing (158 occurrences), employment (eighty-one occurrences), financial inadequacy (forty-one occurrences) and legal problems (nineteen occurrences).

Physical health problems of other members of the family (diet, minor ailments, specific illness) were recorded altogether 135 times, emotional and behaviour problems of older children, adolescents and adults sixty-four times, and employment, housing and finance altogether 306 times. This does suggest that a visit to a presumed "normal" family, where the purpose of the visit if focused on the health of the young child, may lead to the discussion and thence to treatment (including referral) of incipient problems which are not associated with the primary purpose of the visit.

7.5 ***The Effect of the Presence of Other Agencies***

In 822 of the visits recorded some other agency was known to be currently visiting the family in addition to the health visitor.

Analysis of the content of these visits yields some information about areas of possible overlap between agencies visiting the same family. The problem of multiple visiting has been mentioned already; findings about the pattern of such visits are described in Chapter 6, and about the client's part in such visits in Chapter 9. In this section the content of such visits is discussed.

The 567 visits to families where the general practitioner was known to be currently visiting, the sixty-four visits where the midwife was known to be visiting, the 155 visits where the district nurse was known to be visiting, and the 176 visits where either a Welfare Officer or a Child Care Officer was known to be visiting, were analysed as subgroups in order to discover to what extent topics which might be considered more appropriate to the other visiting agency were discussed.

In the 567 visits where the general practitioner was known to be visiting, discussion of specific illness or disability was recorded one 197 times, an incidence of 34·7%, compared with an incidence of 17·9% in the overall sample. In the sixty-four visits where the midwife was known to be visiting discussion of the physical health of the antenatal mother was recorded twenty-four times, an incidence of 37·5% and the mental and social well being of the antenatal mother twenty-one times, an incidence of 32·2%, compared with incidences of 3·9% and 3% respectively in the overall sample. In the 155 visits where the district nurse was known to be visiting, nursing care was recorded sixty times, an incidence of 38·7%, compared with 7·2% in the overall sample.

These were expected findings since it is reasonable to suppose that a health visitor, who is a health worker, would discuss problems of health even where a specialist was also involved, and that in the health field overlap between the health workers visiting is inevitable.

It is often suggested, however, that a distinction should be made between health problems and social problems, and that "Where a health visitor knows that one of 'her' mothers is being helped by a caseworker, she should stick to her primary concern of health teaching. . . . In her visits she should restrict herself to advising the family on matters of health and resist the temptation to hand out 'social advice' unless she has consulted the caseworker and both know what help and advice the other is giving." (Rodgers and Dixon 1960, p. 217).

The content of the group of 176 visits where a Welfare Officer or a Child Care Officer was known to be visiting is compared with the group of 1,881 visits where they were not thought to be visiting (Figure 7). The difference between the two groups is considerable.

On visits where the social worker was known to be visiting 30·8% of topics recorded were specifically concerned with young children, compared with 44·3% of topics recorded in visits where no social

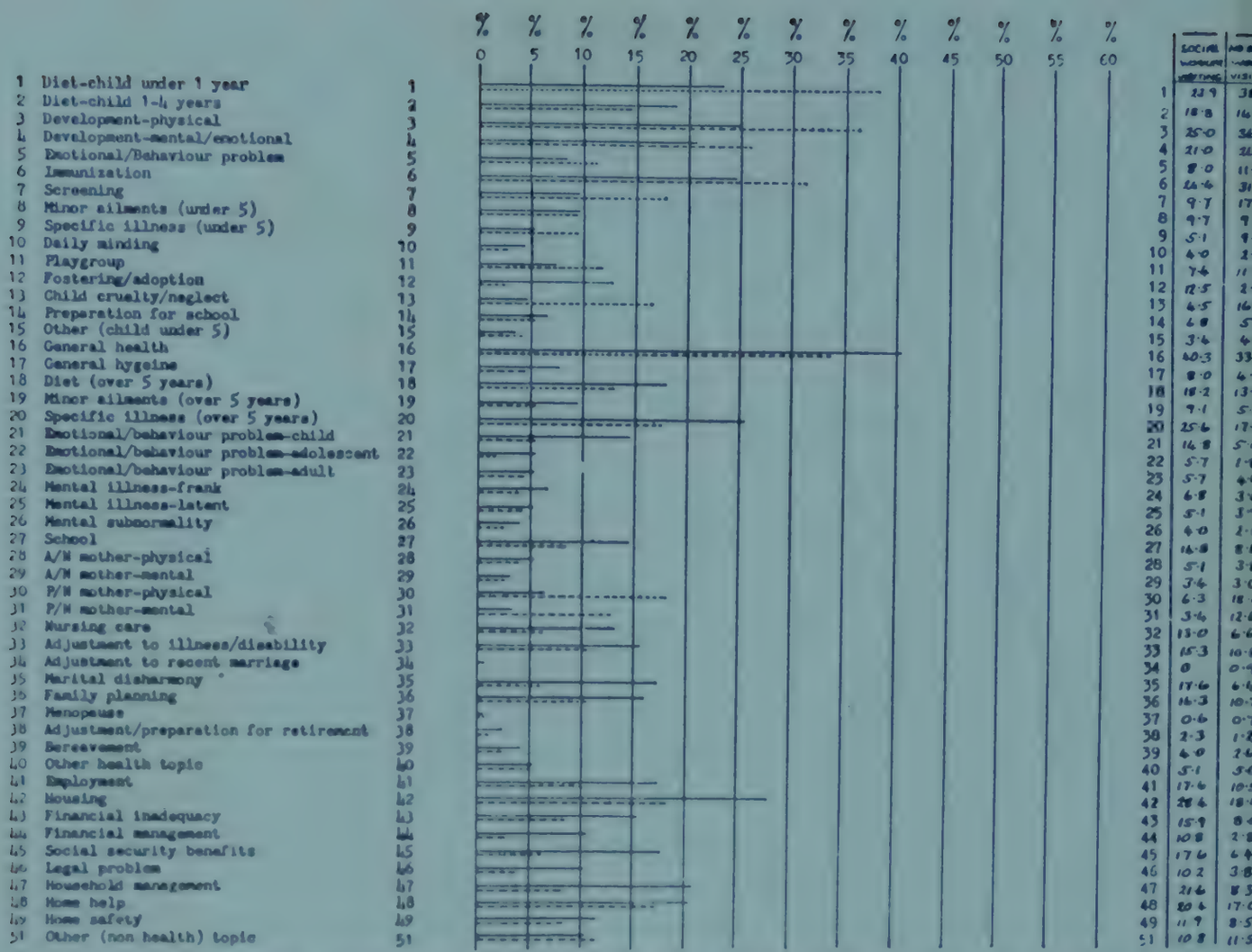

Fig. 7. INCIDENCE OF TOPICS RECORDED IN VISITS TO FAMILIES WHERE A SOCIAL WORKER WAS KNOWN TO BE VISITING

—— social worker visiting
—— no social worker visiting

worker was visiting. In visits where the social worker was known to be visiting "social" topics constituted 36·1% of all topics recorded, compared with 25·1% of all topics recorded in visits where no social worker was visiting. The differences are significant at P.001. In visits where the social worker was visiting the incidence of all social topics was considerably higher than in other visits, often by as much as a factor of two.

It would appear that when she visits families who are also visited by a social worker the health visitor does not "restrict herself to matters of health."

CHAPTER 8

The Health Visitor's Approach

One component of the verbal interaction between health visitors and their clients in home visits, that of the subject matter, has been discussed in the previous chapter. This chapter considers another important component—the approach of the health visitor.

In recent years the didactic and authoritarian approach in professional-client relationships has fallen into disfavour. It has been suggested that the professional must not be overtly assertive with the client, that the aim should be not to provide solutions to the client's problems but to make it possible for the client to move towards greater insight into his problems and perhaps to visualize for himself better solutions for them. This is the approach used in social casework; it is contrasted with the didactic and authoritarian approach which is considered to be an integral part of the nursing role. Because basic nurse training is a pre-requisite for entry into health visiting it is sometimes suggested that the health visitor is unable to relinquish her former nursing role and that she continues to use the authoritarian approach which is a major component of the stereotype of the health visitor as was described in Chapter 1.

In a study of Scottish health visitors Hunt (1972) has reported that 60% of her health visitor respondents considered that they had to change or modify many attitudes which they had acquired during hospital training when they entered health visiting; the attitude change which they considered most important was the change from authoritarian attitudes to more permissive and non-judgemental ones.

8.1 *Methodological Considerations*

A means of analysing this component of verbal behaviour between public health nurses and their clients has been developed by Johnson and Hardin (1962). A series of specific indices was devised for measuring various dimensions of "verbal involvement" which they defined as "an inter-related complex of several kinds of verbal activities observed among the participants, including participant initiative in raising ideas and topics, volume of talk in pursuing ideas and topics, the use of such forms of communication as asking questions, answering questions, advising and instructing." Two of the dimensions studied were the

"dominance dimension" and the "teaching or health counselling dimension."

Three measures of the "dominance dimension" were available—relative verbal output, initiation of ideas, and the client's response to questions—and these were found to be closely interrelated. The "teaching or health counselling dimension" was measured in terms of the proportion of the nurse's verbal output allocated to advice and instruction. The unit of measurement in the case of proportion of verbal output was duration, and in the case of initiation of subject matter was frequency of occurence.

These two dimensions studied by Johnson and Hardin were thought to be particularly relevant to a consideration of the stereotype of the health visitor. Although Johnson and Hardin's method of collecting the data was beyond the scope of this study, it was thought that by using frequency of occurrence as the unit of measurement for both indices, it was possible to adapt the system used by Johnson and Hardin for analysing data recorded verbatim and later classified by non-participant assessors, to data obtained by means of a self-administered instrument such as the visit schedule.

Accordingly, in recording the occurrence of each item of subject matter on the visit schedule, the respondent also recorded whether she or the client had introduced the topic, and at which of three "levels" the item had been discussed. The levels were defined as follows:

Level 1: Listening and reassurance only.
Level 2: Discussion plus some factual information.
Level 3: Discussion plus some positive advice or teaching.

The validity of the results obtained is limited in the same way as the validity of other parts of the study, namely that a self-administered instrument can provide only a subjective assessment of what actually happened. Nevertheless the results do offer some empirical evidence about the distribution of patterns of verbal behaviour among health visitors which reflect varying degrees of "dominance", and they can therefore provide some estimate of how far the health visitors in this study conformed to that part of the stereotype which describes them as "authoritarian and didactic in approach."

8.2 *Initiation of Subject Matter*

Just over half (57·2%) of all topic occurrences recorded were introduced by the health visitor. This proportion is lower than that recorded by Johnson and Hardin (67%). The proportions differed however within the topic groups; the health visitor initiated 62·7% of topics concerned with physical health care, compared with 52·6% of the topics concerned with social care, and 49% of the topics concerned with mental health care. These differences are significant at P.001. The health visitor initiated 60·5% of the topics concerned with young children,

compared with 54·7% of other topics; this difference also is significant at P.001.

Certain topics were almost always introduced by the health visitor while others were usually introduced by the client. The former group included screening procedures (89·2% of all occurrences were introduced by the health visitor), home safety (86·2%), care of the post-natal mother (82%), home help (78·9%), general hygiene (78·3%), immunization (76·1%), and preparation for school (73%). Topics concerned with emotional or behaviour problems were usually initiated by the client; the menopause (85·7%), adjustment to recent marriage (81·2%), marital disharmony (80·1%), legal problems (80%), adolescent behaviour problems (78·1%), and bereavement (77·2%).

In general terms, therefore, the health visitor was marginally the dominant figure in establishing the patterns of flow of subject matter, and in some areas of subject matter she was more dominant than in others. Clients differ vastly, however in the degree to which they attempt to dominate the flow of subject matter; the extent to which the health visitor directs the initiation of topics and can thus control the direction of the conversation is therefore partly dependent on the characteristics of the family she is visiting. The proportion of topic occurrences introduced by the client in visits to households containing young children (40·4%), was not significantly different from the proportion (40·7%), in visits to the elderly, but there was a significant difference between the proportions in these two groups and that in visits to "other" households (50·4%).

The proportion of topics initiated by the health visitor differed markedly, however, with the age and date of qualification of the health visitor. This finding is discussed in Chapter 11. It is interesting to note that Johnson and Hardin found that the "dominance dimension" did not vary with the age and training of the nurse.

8.3 *Levels of Verbal Involvement*

A second measure of the approach of the health visitor was thought to be the amount of positive advice which she gave, as opposed to listening, reassurance, and factual information. Overall the proportion of topic occurrences in which positive advice was given (Level 3) was surprisingly low—19·0%, compared with Level 2 (36·2%) and Level 1 (39·9%). In the remaining 4·9% of occurrences the "level" was not specified.

As in the pattern of topic initiation, there were considerable differences between the relative proportions in different subject matter areas. The health visitor gave advice more frequently in topics concerned with physical health care (22·3%) than in topics concerned with mental health care (19·2%), and topics concerned with "social" care (15·7%). Topics concerned with mental health care were usually discussed at Level 1 (48·0%), and "social" care at Level 2 (41·4%). This shows the

different ways in which the health visitor may deal with the problems presented. In dealing with emotional difficulties her role is primarily to listen and support; in dealing with "social care" topics to provide factual information about what services are available and how they may be used. Similarly topics concerned with young children were more frequently recorded at Level 3 (23·7%) than topics not concerned with children (17·3%), because the care of young children is the health visitor's field of special expertise and one in which she has clearly an advisory as well as a supportive function.

The relative proportion of advice compared with reassurance and information was low for all topics. In only five topics did the level exceed 30%. These were diet of child under one year (37·7%), specific illness of young child (32·0%), child neglect (37·5%), financial management (31·0%) and home safety (30·4%). Several subjects were most frequently recorded at Level 2 (factual information): these were immunization (61·3%), playgroups (60·8%), screening procedures (58·9%), home help (57·2%), daily minding (56·7%), family planning (55·6%), social security benefits (51·0%), and legal problems (51·0%). Topics usually dealt with at Level 1 (listening and reassurance only), included bereavement (64·9%), the menopause (64·3%), adolescent behaviour problems (62·8%), school (56·8%), marital disharmony (56·3%), employment (56·5%), and housing (55·2%).

The health visitor's approach varied with the type of family she was visiting. Advice was at its highest (20·6%) in visits to families where there were young children, less (14·5%) in visits to the elderly, and still less (13·4%) in visits to "other" households.

Her approach also varied, not surprisingly, with the purpose of the visit. Where the purpose of the visit was to deal with a problem of child management the incidence of positive advice (Level 3) was 24·7%, where the purpose was to give emotional support, the incidence of advice was almost halved (13·4%), while the incidence of listening and reassurance (Level 1) rose from 35·6% to 47·1%.

Marked differences were found, as in the pattern of subject matter initiation, according to the age and date of qualifications of the health visitor. These differences are discussed in Chapter 11.

8.4 *Problems of Interpretation*

The interpretation of these findings is extremely difficult. It depends on an assessment of the validity of the method of using a self-recorded "level of involvement" as a measure of the health visitor's approach, and also on value judgements which equate "reassurance only" with "good" and "positive advice" with "bad". Johnson and Hardin found that neither content nor approach was related to the age or training of the nurse; they found, however, the same relationship between subject matter and approach as was revealed by this study. Johnson comments "Perhaps it is through intensive case analysis, within which a number of

unique configurations can be delineated through careful study of multiple forces simultaneously, that the most promising results will be obtained. We know that households have varying interests and varying capacities to express these interests; when these are coupled with perceptual differences among nurses about the most important issues to discuss, and when all of these insights are applied to individual cases, it may be possible to provide a more realistic interpretation of the focus of the visit." (Johnson 1969.)

CHAPTER 9

The Client's Part in the Visit

We have very little information about the consumer's view of health visiting. The only information the writer has been able to discover is contained in a study (P.E.P. 1961) of the consumer's view of several social services in which respondents were asked how satisfied they had been when they had used various services, and what improvements they wanted. Relatively few mothers were dissatisfied with their use of the welfare clinic (8%) or the health visitor's home visits (11%), but no information was included about the content of the contact between client and health visitor.

It was not part of this study to direct any questions to the client whom the health visitor was visiting, and consequently information about the client's perception of the visit is limited to the health visitor's report. Analysis of the visit schedules did however yield information which is interesting as indirect evidence particularly since so little information about the consumer's view is available elsewhere.

There were two sources of information. First, a question in the first part of the visit schedule asked who had initiated the visit, and the 280 visits which were initiated by the client were analysed as a sub-group. Secondly, in recording the topic pattern of each visit, the health visitor indicated whether she or the client had introduced each topic; this yielded information about which topics clients most often raised in different situations, and which topics, when they were discussed, were usually raised by the client rather than by the health visitor.

9.1 *Visits Initiated by the Client*

Of the 2,057 visits which were recorded, 280 were reported to have been initiated by the client, a proportion of 13·6%. This compares with a proportion of 6% in the studies of the work of seventy-seven health visitors carried out in six areas for the Jameson Committee in 1954, and a proportion of 8·9% in the study carried out by Akester and MacPhail in Leeds in 1961. In her study of all the work of all the social welfare staff (including health visitors) in Buckinghamshire, Jeffereys (1965) recorded a client initiation rate of 24%.

The reasons for these differences are not clear. Jameson commented that it was more likely that matters on which clients wished to consult health visitors were dealt with at visits initiated by health visitors than

because they were unwilling to discuss problems with her, but suggested that it was possible that, if the frequency of regular visits were reduced, more requests from clients might follow. Since 1954 "routine visiting" (i.e. regular visits at prescribed intervals to every child) has in fact gradually been replaced in most areas, including Berkshire by "selective" visiting (visiting at irregular intervals, decided by the health visitor herself in the light of her assessment of need, with concentration on those children and families thought to be most "at risk"). It would be erroneous to conclude that the increase in the proportion of visits initiated by the client is the fulfilment of the Jameson prediction; many other reasons are possible, e.g. greater proportion of families in Berkshire in 1969 having telephones with which to contact the health visitor than in Jameson's six areas in 1964.

Akester and MacPhail (1964) argued that the health visitor should be well known in her "parish" and suggested that this advantage would be lost where the health visitor worked in an attachment scheme rather than a geographical area; they also suggested that it was an advantage that the health visitor could be recognized by her uniform. In the light of these observations it is interesting that the proportion of visits initiated by the client in this study in Berkshire, where all the health visitors were attached to group practices and none wore uniform, was higher than the Leeds study.

(a) *Clientele*

The great majority of visits initiated by the client were, as in the total sample, made to families where there were young children; 11% were to the elderly and 15% to households where there was neither an elderly person nor a young child (Table 23). These proportions differ

TABLE 23

Type of Household in Visits initiated by the Client and by the Health Visitor

Type of household	Visits initiated by Client	Visits initiated by Health Visitor	All visits
Households containing child under 1 year	40·0	52·5	44·3
Households containing child 1–5 years	33·2	25·0	26·3
Households containing elderly person	11·1	14·1	18·0
Other (containing neither elderly nor young child)	15·0	8·0	10·9
Not specified	0·7	0·4	0·5
Total	100·0 (280 visits)	100·0 (1,306 visits)	100·0 (2,057 visits)

however from the proportions in the total sample. The difference is significant at P.001. This suggests that some clients are less likely to request a visit than others. Mothers of young babies and elderly people were less likely to have initiated the visit than mothers of toddlers (including families where there may also have been a baby) and families where there was neither an elderly person nor a young child. It is perhaps a cause for concern that the groups which might be thought to be in greatest need of a visit (mothers of first babies, and the elderly) were the groups least likely to ask the health visitor to call. One possible explanation is that the client is likely to initiate the visit only if he or she has built up a good relationship with the health visitor by means of previous visits. This might explain the higher proportion of client initiated visits to families with toddlers (in 74·3% of which the health visitor had visited more than once before); however, the proportion of visits to households containing neither a young child nor an elderly person in which the health visitor had visited more than once before was lower than in the total sample, whereas the proportion of visits to the elderly where the health visitor had visited more than once before was not. Another explanation is that these two groups (first babies and the elderly) are recognized by the health visitor as particularly vulnerable and are therefore visited more frequently on the health visitor's own initiative; in fact more than half (52·5%) of the visits initiated by the health visitor were to families containing a child aged under one year but the proportion of visits to the elderly was slightly lower (14·1%) than in the total sample.

(b) *Purpose*

Why did the client ask the health visitor to call? The answer to this question must yield some information about the client's perception of the function of the health visitor. The purpose recorded is, of course, that ascribed by the health visitor. The purpose most commonly described for a client-initiated visit was to deal with a specific problem of child management (34·3%); next came the provision of other social services (19·6%), and then emotional support (11·1%). This distribution is very different from that of the total sample.

9.2 *Subject Matter Introduced by the Client*

Forty per cent of all the topics discussed were introduced by the client; the proportion was, as might be expected, higher (56·6%) in visits initiated by the client.

This overall figure probably suggests more about the approach of the health visitor than about the perceptions of the client, but some indication of the client's perceptions is given by an analysis of the *type* of topic introduced by the client, i.e. the relative proportions when the topics were grouped, and individual topics which were introduced far more frequently by the client than by the health visitor.

When the topics were grouped into those specifically concerned with children under five years and those not specifically concerned with children under five years, the proportion of topics not specifically concerned with young children was higher (59·9%) in topics introduced by the client than in the topics introduced by the health visitor (54·5%) (Table 24). The difference is significant at P.001. The difference was

TABLE 24

Relative Proportions of Topic Groups in Topics introduced by the Client and by the Health Visitor

Topic Groups	Percentage of Topic Occurrences introduced by	
	Client	Health Visitor
Physical	47·2	58·7
Mental	22·9	16·5
Social	29·0	24·2
Unclassified (Topic 15)	0·9	0·6
Total	100·0 (4,341 occurrences)	100·0 (6,007 occurrences)
Concerned with young children	40·1	45·5
Not concerned with young children	59·9	54·5
Total	100·0 (4,341 occurrences)	100·0 (6,007 occurrences)

repeated in the analysis of the subgroup of visits made to households containing young children; 47·1% of topics introduced by the client were not concerned with young children compared with 45·6% of topics introduced by the health visitor.

Of all the occurrences of topics concerned with young children 38·6% were introduced by client, compared with 43·4% of all occurrences of topics not concerned with young children. This difference was repeated in all subgroups.

Of the thirteen topics which were introduced by the client at least twice as often as by the health visitor, only three, emotional or behaviour problem of a young child, minor ailments of young children, and child cruelty or neglect were specifically concerned with young children.

These findings suggest that the client perceived the health visitor as someone whose knowledge is not limited to the management of young children although, since it is to deal with some problem of child management that she is most commonly asked to visit, child management is seen as her main area of expertise.

When the topics were grouped into those concerned with "physical

health care", those concerned with "mental health care", and those concerned with "social care", the relative proportions in topics introduced by the client were different from the proportions in topics introduced by the health visitor. The difference is significant at P.001. In those introduced by the client the proportions of topics concerned with mental health care and with social care were higher than in those introduced by the health visitor; this difference was, with one exception, repeated when the sub-groups of visits to each type of household were analysed separately. The exception was the proportion of topics concerned with social care in visits to the elderly; here the proportion in topics introduced by the client was lower than in topics introduced by the health visitor.

Of all the topics concerned with mental health care almost half (49·2%) were introduced by the client, and of all topics concerned with social care 45·5% were introduced by the client, compared with 36·4% of topics concerned with physical health care. These differences persisted in all subgroups, with the same single exception as previously mentioned—topics concerned with social care in visits to the elderly.

Of the thirteen topics which were introduced by clients at least twice as often as by health visitors only three (minor ailments of young children, minor ailments of others, and the menopause) were concerned with physical health. Emotional or behaviour problems of all age groups (children, adolescents, and adults) were raised by clients more than twice as often as by health visitors.

The topics raised most often by clients were different from the topics raised by the health visitor. Physical development of children and infant feeding ranked in the top four in both groups, but housing, specific illness, emotional or behaviour problems of young children, financial inadequacy, employment and marital disharmony ranked in the twelve topics most frequently introduced by the client whereas none of these ranked in the twelve topics most frequently introduced by the health visitor.

9.3 *The Client and Other Agencies*

In 822 of the visits recorded some other agency in addition to the health visitor was known to be currently visiting the family. In these cases topics which were raised by the client in discussion with the health visitor could have been raised with the other agency, and analysis of the material yields some information about areas of possible overlap between different agencies visiting the same family. This has been discussed in some detail in Chapters 6 and 7, and is discussed here only in relation to the client's perception of the health visitor.

It has been suggested by Rodgers and Dixon (1960) that where a social worker is visiting a family which is also visited by a health visitor, the health visitor should confine her concern to problems of health and child management, leaving social and emotional problems to be dealt

with by the social worker. Health visitors themselves have long contested the practicability of such a division. It would be invaluable in planning and administering the social services to know how far the client perceives differences in the functions of the various social agencies with whom he or she has contact.

It has already been shown in Chapter 7.5 that in visits where a social worker was known to be currently visiting the family the relative proportions of "mental health care" and "social care" topics were raised. When the topics introduced by the client are analysed separately, these differences are seen to be accentuated.

In the 103 visits recorded to families where a Child Care Officer was known to be currently visiting, the proportion of topics introduced by the client which were not specifically concerned with young children was higher (62·6%) than in topics introduced by the health visitor (51·9%), and higher than in topics introduced by the health visitor in the overall subgroup of households containing young children (47·1%).

Of the 138 occurrences of "mental health care" topics, 58·7% were introduced by the client, and of the 232 occurrences of "social care" topics 52·2% were introduced by the client compared with 43·5% of the 310 occurrences of "physical health care topics". Of the "social care" topics, only daily minding, playgroup, preparation for school, financial management, household management, and home safety were introduced more frequently by the health visitor than by the client; housing was introduced seventeen times by the client compared with nine times by the health visitor, financial inadequacy fifteen times by the client compared with four times by the health visitor, and marital disharmony twenty times by the client, compared with twice by the health visitor. The topics most frequently raised by clients in these visits differ from the topics most frequently raised by health visitors.

It should be noted that the numbers in the analysis of visits to families where a Child Care Officer was known to be visiting were small (103 visits and 684 topic occurrences), but it does appear that clients who had the opportunity to raise psycho-social problems with a social worker nevertheless raised them with the health visitor, and that they raised these topics more frequently than they raised topics concerned with physical health or child management. This suggests that the client does not "sort" his or her problems and does not limit the topics discussed with a health visitor to those which either the health visitor or the social worker might consider more appropriate for discussion with a health visitor than with a social worker.

CHAPTER 10

The Role of General Practitioner

10.1 *Introduction*

Relationships between health visitors and general practitioners have not always been cordial. General practitioners are notoriously poorly informed about other health and social welfare services, and until a health visitor is attached to his practice a general practitioner may have very little personal contact with the health visiting service. Where contact did occur it was usually through the intermediary of a patient who was receiving advice from both health visitor and general practitioner; the advice from the two sources, perhaps *because* there was no communication between them, often conflicted, and the patient was able to "play" one adviser against the other:

"Health visitors can be a great nuisance. For example after I have argued in favour of breast feeding they visit and insist that a baby should be fed on Cow and Gate, at least that is the patient's version." (Wessex Regional Hospital Board 1964, p. 61.) Before the inception of the National Health Service resentment may also have been caused by the fact that the health visitor's advice was not only independent, it was also free, whereas the advice of the general practitioner usually had to be paid for.

Sometimes the problem is one of simple ignorance. Cartwright (1970, p. 127) records an example of a general practitioner who said: "Who are the health visitors? Are they the ones who go round to see if the babies are deaf?" More often resentment is caused by limited knowledge rather than complete ignorance, particularly where the general practitioner fails to understand, and consequently undervalues the health visitor's preventive role but sees her primarily as some sort of medical auxiliary who will lessen his workload. In an article entitled "A Possible New Look" a general practitioner outlined the work which he thought a health visitor should undertake in his practice:

"If a health visitor attended even every other session (daily meeting over coffee of the four doctors and nurse-receptionist of the practice) she could be found very useful employment. First . . . the elderly, alternate visits by a health visitor and ourselves at say three weekly intervals would help all round. . . . A very obvious job would be to ensure that they (tablets) were being taken in the right way at the right time. . . . In our case we would not need her attendance at the (baby)

clinics as our own staff do the weighings. . . . I can safely say that in the case of our 9,000 patients the above programme would cover all their health visitor needs and all the health visitor's work would be useful, worthwhile stuff." (Arthur 1967, p. 381.)

The development of attachment schemes has been described in Chapter 2, and it is clear that where health visitors have been attached to general practices there has been much greater mutual understanding and respect between health visitors and general practitioners and relationships between them have greatly improved. During the past decade a large number of descriptive studies of attachment schemes have been published; those written before 1970 have been ably analysed and collated by Hawthorn (1971). Certain general conclusions appear to emerge from all the studies. The advantages of attachment are described in terms of better co-ordination of patient care, increased job satisfaction, improved understanding between general practitioner and health visitor, as well as changes in the health visitor's work. The change in work most frequently ascribed to attachment is an increase in contact by health visitors with people of age groups other than young children, in particular with the elderly, and it is suggested that the increase is due to the increased number of referrals made by the general practitioner. In addition to the increased number of referrals, attachment affords opportunities for case-finding by the health visitor on her own initiative; access to the practice records should enable her to identify vulnerable groups within the practice population and to act as she considers appropriate.

Two potential disadvantages of attachment have been greatly discussed but not demonstrated by any research. First, it is suggested that attachment results in a tendency for the health visitor to move from preventive into curative work, and that this constitutes a mis-use of health visiting skills; a second danger is the potential loss of the health visitor's professional independence because her work may become subject to the general practitioner's direction. These two factors are further discussed in Chapter 13.

10.2 *Contact between Health Visitors and General Practitioners*

Several studies, in particular that of Ambler (1968) have shown that where health visitors are attached to general practice the frequency of contact between health visitor and general practitioner and the amount of time spent in direct consultation are much greater than where health visitors are not attached. This study did not record either time spent in consultation or rate of contact, but the health visitors did record which of a number of agencies they had been in contact with during the past week and during the past month. All but one of the seventy-eight health visitors had been in contact with the general practitioner during the past week.

10.3 *Visits Initiated by General Practitioners*

One measure of the amount of direction which the general practitioner exerts over the health visitor's work is the proportion of her visits which he initiates. A study of non-attached health visitors in Leeds (Akester and MacPhail 1963) recorded a proportion of 0·5%. At the other extreme, Gilmore (1971) in a study of the work of an attached nursing team in Brighton, recorded a proportion of first visits (a figure for all visits was not given) initiated by the general practitioner as high as 43%. A proportion as high as this suggests that attachment does bring new cases to the notice of the health visitor, but it also suggests that she is acting less as an independent practitioner and more as an agent of the general practitioner.

In this study 7·3% of the visits were initiated by the general practitioner, a small proportion when compared with the proportion initiated by the health visitor herself (63·5%) or by the client (13·6%) and certainly not large enough to support the suggestion of direction of the health visitor's work by the general practitioner. The "right" level of referral is difficult to determine. In the end, however, it is the responsibility of the health visitor to determine her own priorities in visiting, whatever the referrals she receives; the extent to which the general practitioner directs her work is a function of her own conception of her role and her confidence in herself as an independent practitioner.

The visits initiated by the general practitioner in this study (150 visits) were analysed separately in an attempt to discover whether these visits differed in any way from visits made on the health visitor's own initiative (1,306 visits) or on that of the client (280 visits). It was considered that any differences would provide evidence about the suggestions made about possible effects, good and bad, of attachment on the health visitor's work. The differences are shown in Tables 25–27.

TABLE 25

Duration of Visits initiated by the General Practitioner, the Client, and the Health Visitor

Duration of visit	Percentage of visits initiated by		
	General Practitioner	Client	Health Visitor
Under 15 minutes	20·7	25·4	27·7
15–29 minutes	43·3	48·9	54·6
30–59 minutes	29·3	19·6	14·9
60 minutes or longer	6·0	5·7	2·5
Not specified	0·7	0·4	0·3
Total	100·0 (150 visits)	100·0 (280 visits)	100·0 (1,306 visits)

TABLE 26

Type of Household in Visits initiated by the General Practitioner, the Client, and the Health Visitor

Type of household	Percentage of visits initiated by		
	General Practitioner	Client	Health Visitor
Households containing child under 1 year	23·3	40·0	52·5
Households containing child 1–5 years	15·3	33·2	25·0
Households containing elderly person	38·7	11·1	14·1
Other households	22·0	15·0	8·0
Not specified	0·7	0·7	0·4
Total	100·0 (150 visits)	100·0 (280 visits)	100·0 (1,306 visits)

TABLE 27

Purpose of Visits initiated by the General Practitioner, the Client, and the Health Visitor

Recorded purpose	Percentage of visits initiated by		
	General Practitioner	Client	Health Visitor
Routine (child under 5 years)	3·3	6·1	35·3
Primary visit	—	1·1	11·3
Screening procedure	1·3	2·1	13·3
Arrange services	24·0	19·6	10·6
Physical health problems	6·7	4·6	1·8
General surveillance	6·7	1·8	8·2
Emotional support	8·0	11·1	7·0
Child management	14·7	34·3	4·3
Total assessment	18·7	5·4	2·7
Other	16·7	8·2	5·0
None (chance meeting)	—	1·4	—
Not specified	—	4·3	—
Total	100·0 (150 visits)	100·0 (280 visits)	100·0 (1,306 visits)

(a) *Duration*

Although the proportion of visits initiated by the general practitioner was relatively small, these visits tended to be of longer duration than visits initiated either by the health visitor herself or by the client. More than a third of these visits lasted longer than half an hour, compared with a quarter of those initiated by the client, and a sixth of those initiated by the health visitor herself.

(b) *Clientele*

The groups which the general practitioner asked the health visitor to visit were in general those with which the non-attached health visitor has little contact. Just over 60% of the visits initiated by the general practitioner were to families where there were no young children, while the great majority (77·5%) of the visits initiated by the health visitor herself were to families where there were young children. The proportion of visits to the elderly was almost three times as great among visits initiated by the general practitioner as among visits initiated by the health visitor herself.

Moreover, in 40% of the visits initiated by the general practitioner, the health visitor had not previously visited the family, compared with 16·4% of visits initiated by the health visitor; in sixty cases the general practitioner had put the health visitor in touch with a problem which she would probably not otherwise have known about. This suggests that attachment does afford the health visitor increased opportunity for finding new cases.

(c) *Purpose*

In ten (6·6%) of the visits initiated by the general practitioner the purpose was described as "deal with a physical health problem". The purposes most commonly described were "to arrange services" (thirty-six visits, 24%) and "total assessment" (twenty-eight visits 18·7%). This hardly supports the fear that the health visitor will be drawn into curative work with the sick; it suggests rather that the health visitor plays the role within the practice team of liaison agent between the general practitioner and the other social services.

(d) *Content*

The topic pattern of the visits initiated by the general practitioner differs from that of other visits. The topics most frequently recorded were general health of the family (fifty-four occurrences, incidence 36%); specific illness or disability (fifty-four occurrences, incidence 36%); home help (forty-three occurrences, incidence 28·6%); adjustment to illness (forty occurrences, incidence 26·6%), and diet (thirty-eight occurrences, incidence 25·3%), and these incidences were much greater than in visits initiated by the health visitor. The incidence of

several other topics was much greater than in other visits; these topics included emotional problems of adults (9·3% compared with 4·5% in the total sample); frank mental illness (8·6% compared with 3·8%), bereavement (6·6% compared with 2·8%), social security benefits (12·6% compared with 7·3%). This suggests that where the health visitor is dealing with sick people and their illnesses she tends to concentrate on the social and emotional aspects of the illness.

This suggestion appears to be confirmed when the topics are grouped in broad areas of subject matter: the proportion of topics concerned with physical health was 45·8%, with mental health 23·2%, and with social care 30·6%— a lower proportion of topics concerned with physical health and a higher proportion of topics concerned with the psycho-social aspects of health than in the sample as a whole.

10.4 *Conclusions*

All the health visitors in this study were attached to general practice; in Berkshire at the time of the study the policy of attachment was well established. The findings of the study do not confirm either the fears expressed by those who oppose attachment schemes, or all the hopes of the policy's most ardent supporters.

The desirability of attachment schemes has usually been described in terms of the increased job satisfaction which working in attachment brings to both doctors and nurses. The most important criterion ought, however, to be an improvement in the quality of patient care. This factor has not yet been systematically investigated although those who work in attachment schemes frequently express the opinion that the quality of care is improved. This is clearly an area where further research needs to be undertaken.

In this study the small proportion of visits initiated by the general practitioner does not support the suggestion of direction of the health visitor's work by the general practitioner, and analysis of the purpose and content of these visits does not support the suggestion that the health visitor in attachment is drawn into curative work. The increase in the social component of these visits compared with other visits suggests rather that the health visitor is dealing primarily with the social and psychological effects of illness, which may be regarded as part of her normal role in tertiary prevention.

Within general practice the health visitor is in a unique position to identify individuals at times of potential breakdown. This study shows that attachment does increase the health visitor's contact with groups other than young children and with problems of which she would not otherwise have been aware. The small proportion of visits initiated by the general practitioner may, however, indicate that at present attached health visitors may not be utilizing to the full the opportunities for case finding which attachment can provide.

The mere fact of attachment does not change the health visitor's work in any way; her potential clientele is the same whether people are listed according to the street in which they live or according to their general practitioner, and her statutory duties remain unchanged. Any changes in clientele are the result of decisions which must be made jointly by doctors and nurses about which vulnerable groups ought to be followed up and what machinery needs to be devised to enable this to be done. Any change in emphasis in work content and the extent to which the health visitor allows her work to be directed by the general practitioner are the responsibility of the health visitor herself. Attachment does not create the changes; it merely provides the opportunity.

CHAPTER 11

The "New Breed" Health Visitor

11.1 *Introduction*

New regulations for entry to health visiting and a new syllabus of training were introduced by the Council for the Training of Health Visitors in 1964 and came into operation in 1965. In the new syllabus considerably more emphasis than previously was placed on the emotional and social aspects of health and on vulnerable groups other than young children. The Council described the new syllabus as "based on the view that the health visitor's task has two main aspects; first the assessment of the health potential of the individual and family group, and provision of appropriate health education; and, secondly, assessing the health needs of the handicapped of all age groups, the implication of their care on the family and their continued maintenance and support in the community." (The Council 1965).

In an attempt to discover whether the new syllabus of training had, in fact, changed the way in which health visitors worked, all the visits recorded by health visitors who had qualified since 1965 were analysed as a subgroup and compared with the subgroup of visits recorded by health visitors who had qualified before 1960. The visits recorded by health visitors who qualified between 1960 and 1965 were excluded from the analysis because this period marked a transitional phase in which certain progressive training schools began to modify their courses in anticipation of the new syllabus, while others continued to train according to the old pattern.

In this study thirty-two (40·5%) health visitors had qualified before 1960 and twenty-three (29·1%) since 1965.

11.2 *Pattern of Visiting*

There were considerable differences between the two groups in terms of the pattern of visiting, the subject matter of the visit, and the health visitor's approach.

(a) *Clientele*

There were differences in the clientele of health visitors who qualified before 1960 and those who qualified after 1965 (Table 28). The differences are statistically significant at P.02. The proportion of visits to

TABLE 28

Households visited by Health Visitors who qualified before 1960 and after 1965

Type of household	Percentage of visits recorded by Health Visitors qualified	
	Before 1960	After 1965
Households containing child under 1 year	43·4	48·2
Households containing child 1–5 years	28·3	24·8
Households containing elderly person	18·2	13·5
Other households	9·9	12·5
Not specified	0·2	1·0
Total	100% = 771	100% = 1,159

families with young children is approximately the same, but within this group, recently qualified health visitors visited more families with a young baby, and fewer families where there was a toddler but no young baby. They visited fewer elderly people and more in "other" age groups.

The reasons for these differences are not clear. The 1965 syllabus lays greater emphasis on the need for selectivity in visits to families with young children and on the needs of other groups. It is likely however that external factors such as caseloads, geographical area, etc., are important, and also the fact that very recently qualified health visitors would have been in post for only a short time and might not have had sufficient time to establish contact with the whole of their caseload.

TABLE 29

Purposes recorded by Health Visitors who qualified before 1960 and after 1965

Recorded purpose	Percentage of visits recorded by Health Visitors qualified	
	Before 1960	After 1965
Routine (child under 5 years)	29·9	21·6
Primary visit	8·8	7·0
Screening procedure	8·4	9·0
Arrangement of services	13·8	13·1
Physical health problem	2·5	2·1
General surveillance	6·9	5·3
Emotional support	5·7	11·8
Child management	10·2	11·3
Total assessment	5·1	6·7
Other	5·8	8·6
None (chance meeting)	2·1	2·7
Not specified	0·9	0·8
	100% = 771	100% = 1,159

(b) *Purpose*

The differences in the purposes of visits recorded by the two groups of health visitors is statistically significant at P.001 (Table 29). The recently qualified health visitors described a considerably lower proportion of their visits as routine visits to young children, and a considerably higher proportion of their visits as intending to give emotional support. This change of emphasis would conform with the aims of the new type of training. It is important, however, to remember that there may be more than one purpose for a single visit (only the main purpose was coded), and the purpose may be confused with the source of the visit, e.g. "The general practitioner asked me to visit". Moreover the statistics reflect only the purpose as described by the health visitor, and the differences may reflect a change in the approach of the health visitor or in terminology rather than a change in the pattern of visiting.

(c) *Initiation*

The differences in the sources of visits recorded by the two groups of health visitors are shown in Table 30. The difference overall is significant

TABLE 30

Sources of Visits recorded by Health Visitors who qualified before 1960 and after 1965

Visits initiated by	Qualified before 1960	Qualified after 1965
Health Visitor	63·4	59·1
Client	12·8	16·8
General Practitioner	6·5	8·6
Other	17·3	15·5
	100% = 798 visits	100% = 602 visits

at the level of P.06, but not quite significant at P.05, the level which is normally accepted. It is, however, interesting to note the higher percentage of visits initiated by the client and by the general practitioner among visits recorded by the more recently qualified health visitors. The proportion of visits initiated by the client possibly indicates a change in approach of the kind which is discussed later in this chapter. The difference in the proportion of visits initiated by the general practitioner may reflect the difficulty which health visitors who established their patterns of work before attachment schemes began may have in adapting to a new working environment.

11.3 *Content of Visits*

There were considerable differences in the subject matters of visits recorded by the two groups. It was suggested that these differences

might be due to factors other than type of training, in particular to age, especially since date of qualification was highly correlated with age. Accordingly the visits were re-analysed in four groups:

A visits recorded by health visitors aged under forty years who qualified before 1960 (seventy-nine visits);

B visits recorded by health visitors aged over forty years who qualified before 1960 (692 visits);

C visits recorded by health visitors aged under forty years who qualified since 1965 (594 visits);

D visits recorded by health visitors aged over forty years who qualified since 1965 (565 visits).

One hundred and twenty-seven visits could not be allocated to a group because four respondents declined to reveal their age. The number of visits in Group A was considered too small to allow useful comparisons to be made, and this group was therefore discarded.

The difference between the groups in the broad subject areas of physical health, mental health, and social care was not statistically significant, although the younger and more recently qualified health visitors recorded a slightly lower proportion of topics concerned with physical health and a slightly higher proportion of topics concerned with social care than other health visitors (Table 31). Differences

TABLE 31

Relative Proportions of Topic Groups in Visits recorded by Health Visitors of Different Ages and Dates of Qualification

Topic groups	"B" Health Visitors	"C" Health Visitors	"D" Health Visitors
Physical	54·0	53·4	53·1
Mental	19·1	19·9	18·5
Social	26·1	26·2	27·3
Unclassified (Topic 15)	3·8	0·5	1·1
Total	100·0 (3,330 occurrences)	100·0 (3,365 occurrences)	100·0 (2,861 occurrences)
Concerned with young children	44·6	39·9	42·9
Not concerned with young children	55·4	60·1	57·1
Total	100·0 (3,330 occurrences)	100·0 (3,365 occurrences)	100·0 (2,861 occurrences)

Note:

B = Health visitors aged over forty years who qualified before 1960
C = Health visitors aged under forty years who qualified since 1965
D = Health visitors aged over forty years who qualified since 1965.

between the proportion of topics concerned specifically with young children are also shown. Younger and recently qualified health visitors recorded a lower proportion of topics concerned specifically with young children. The difference between group C and group D was not statistically significant, but the difference between group B and group D was significant at the level of P.02; this difference appears, therefore, to be associated with training rather than age.

Differences were more marked when the incidences of certain individual topics were compared (Table 32). In some cases differences

TABLE 32

Incidence of Selected Topics in Visits recorded by Health Visitors of Different Ages and Dates of Qualification

Topic	"B" Health Visitors	"C" Health Visitors	"D" Health Visitors
Emotion/behaviour problem of young child	8·2	15·0	10·3
General hygiene	3·9	5·4	4·6
Diet (person over 5 years)	11·7	17·7	12·9
Specific illness (over 5 years)	15·9	20·9	19·8
Emotional/behaviour problem—child	5·6	7·4	6·0
Emotional/behaviour problem—adolescent	1·7	2·9	2·1
Mental illness—frank	4·2	4·0	3·5
Mental illness—latent	4·2	5·9	2·5
Adjustment to illness	10·4	11·8	12·4
Marital disharmony	6·2	8·8	8·9
Family planning	7·9	19·2	7·6
Bereavement	2·5	3·5	3·0
Employment	10·1	14·0	10·6
Financial inadequacy	6·8	12·1	8·7
Home safety	4·8	14·0	8·5
Relationship building	25·0	41·6	41·2

Note:

B = Health visitors aged over forty years who qualified before 1960
C = Health visitors aged under forty years who qualified since 1965
D = Health visitors aged over forty years who qualified since 1965.

which appear to be due to training are increased by the addition of the factor of age; in some cases the factor to which the difference can be attributed is clear. The recorded incidence of family planning, for example, clearly reflects the age of the health visitor rather than the type of training; the incidence in visits recorded by health visitors aged over forty years is less than half that recorded by health visitors aged under forty years regardless of the date of qualification.

The difference in the recording of marital disharmony, on the other hand, appears to owe more to training than to age; there is little difference according to age, but the difference according to date of qualification is statistically significant at the level of P.01.

The difference in the recorded incidence of the topic "relationship building" is interesting. Relationship building must be a part of every health visitor/client interaction and the absence of a record that it occurred indicates not that it did not occur, but probably that the respondent did not regard it as being of sufficient significance to record it. It is really a measure of approach rather than content, and for this reason was excluded from the analyses of subject matter which were considered in Chapter 7. The figures were, however, included in the original computer print-out for all analyses, and the differences shown in the analysis of schedules according to the age and training of the health visitor were so striking as to be worthy of comment. If frequency of recording of the topic can be considered an indication of the approach of the health visitor, then the large difference in incidence between group B and group D, compared with the small difference in incidence between group C and group D suggests a change in approach which is attributable to difference in training rather than difference in age.

11.4 *The Health Visitor's Approach*

The two main indices used in this study to measure the "dominance" of the health visitor, namely initiation of subject matter and the proportion of verbal output allocated to advice and instruction, have been discussed in general in Chapter 8. There were considerable differences in these indices between health visitors according to their age and training.

In general terms younger and more recently qualified health visitors initiated a smaller proportion of recorded subject matter than other health visitors. Health visitors aged over forty who qualified before 1960 initiated 60·7% of topics recorded. Health visitors aged over forty who qualified after 1965 initiated 58·5% of topics recorded. Health visitors aged under forty who qualified after 1965 initiated 53·1% of topics recorded. The differences are statistically significant according to age (at P.001) and according to training (P.02).

Similar differences were found in the levels of verbal involvement recorded by the three groups of health visitors. Health visitors aged over forty who qualified before 1960 recorded 38·2% of topics at Level 1 (listening and reassurance only) and 21·3% of topics at Level 3 (positive advice and teaching). Health visitors aged over forty who qualified after 1965 recorded 42·0% at Level 1 and 15·1% at Level 3. Health visitors aged under forty who qualified after 1965 recorded 41·1% at Level 1 and 18·0% at Level 3. The differences are all significant at P.001 and it is therefore not possible to distinguish how much they are due to age and how much to training.

11.5 *Interpretation and Implications*

Johnson and Hardin (1962) who first developed these two indices, noted that there were no differences in the "dominance dimension" according to the age and training of the nurse. In this study, however, the younger and more recently qualified health visitors were clearly less dominant than other health visitors according to both indices. Interpretation of this finding is extremely difficult. It depends on an assessment of the validity of the instrument of measurement and also on value judgements which equate low dominance with "good", and high dominance with authoritarianism and "bad." A low level of positive advice and teaching compared with listening and reassurance could be interpreted either as an indication of an easy and relaxed relationship between health visitor and client, or as a lack of confidence on the part of the health visitor. In terms of the stereotype described in Chapter 1, it would appear that both in content and in approach the work of younger and more recently qualified health visitors conforms less closely to the stereotype than that of older health visitors.

The differences in content and approach were more marked than the differences in the pattern of visiting recorded by the different groups of health visitors. This fact is significant because it suggests that the administrative framework of health visiting may not have adapted itself to receive and to utilize the new skills which the new training seeks to provide. It was suggested in the Introduction to this study that the anxiety felt by health visitors about their role and responsibilities was related to uncertainties about the position of the health visiting service in relation to other services and about their own role in relation to that of other workers. It became apparent, however, both during the interviews which formed part of the study and during subsequent discussions with health visitors about its findings, that some of the anxieties expressed were due to factors within the health visiting service itself. In particular it was suggested that caseloads and administrative procedures had not changed to meet changing needs.

If changes in the training of health visitors are not reflected in changes in the service there is a danger that newly qualified health visitors have been trained for a job which they are not allowed to do. Lack of congruence between expectation and reality in the work situation is well recognized as a factor which reduces job satisfaction, damages recruitment, and increases wastage. The problem was discussed, although at that time no evidence was presented, in an article entitled "The Role Conflicts of the New Breed Health Visitor." As the author of that article remarked, "You cannot train a new breed and then expect them to become meek and mild recruits to the old style of health visiting." (Hill 1971, p. 120).

CHAPTER 12

The Stereotype Reviewed

The data in this study concern only the health visitor's perceptions of the situation. This limitation is discussed in Chapter 3. The value of the data lies in their detail and in the fact that the sample of visits was sufficiently large to allow analysis of and comparisons between various subgroups within the sample. No generalizations can be made on the assumption that what is shown to happen in Berkshire happens elsewhere. It is, however, possible to indicate some important features about health visiting in Berkshire, to compare them with the stereotype of health visiting which was described in Chapter 1, and to point to areas which would seem to justify further research.

The stereotype of health visting which was described in Chapter 1 was said to comprise three main elements:

1. Clientele: the health visitor's clientele is limited to young children and their mothers, to the child within the family rather than the family as a unit.
2. Work Content: the health visitor's work is limited to maternal and child welfare, and her chief concern is with physical health and hygiene rather than with the psycho-social aspects of health.
3. Approach: the health visitor's approach in her relationship with clients is didactic and authoritarian rather than non-judgemental and discursive.

12.1 *Clientele*

From this study it appears that the health visitor's clientele, while not limited to young children and their mothers, does consist primarily of families in which there are young children; 70% of the visits in this study were made to such households. The findings do not, however, support the suggestion that the health visitor is concerned primarily with the child within the family rather than with the family as a unit; in visits to households containing young children topics which were not concerned with the young child were recorded in 73·6% of visits and comprised 44·4% of all topics recorded.

A substantial minority (29%) of the visits were made to families where there were no young children, and in particular 18% of all visits were made to the elderly. An apparent shift in emphasis away from the under fives and towards the elderly is illustrated by the Department of

Health and Social Security statistics which record between 1963 and 1971 a reduction in the number of visits to children under five from 3,643,000 to 3,134,540, and an increase in the number of visits to the elderly from 267,000 to 420,865. How far this change can be attributed to administrative policy (in particular to the attachment of health visitors to general practices), and how far to changes in the total population is not clear. During the decade 1961–1971 both groups increased in number and as proportions of the total population. The under five age group increased by 11% from 3,665,000 (7·9% of the total population), to 4,116,000 (8·3% of the total population) and the over sixty-five group increased by 16·8% from 5,521,000 (11·9% of the total population) to 6,446,000 (13·0% of the total population).

The proportion of visits to the elderly recorded in this study is double that recorded in the Department of Health and Social Security returns during the same period, but substantially less than the proportion recorded in some other studies. Some of the factors which may explain the wide variation were discussed in Chapter 5. In the case of the elderly, clearly one important factor is the age structure of the population; it is not surprising that studies in Brighton and Worthing record a higher proportion of visits to the elderly than studies undertaken elsewhere. It does appear, however, that the proportion of visits to the elderly recorded by attached health visitors is greater than the proportion recorded by non-attached health visitors; this finding is consistent in studies of the work of health visitors before and after attachment, and of attached and non-attached health visitors working in the same area.

The health visitor's clientele in any area is very greatly influenced by local administrative policy. For example the very low proportion (2%) of elderly people among health visitors' clients reported by Marris (1971) may be partly explained by the employment in London of specialist geriatric visitors. In another study Goldberg *et al.* (1968) reported that in a general practice to which both a health visitor and a social worker were attached a *modus vivendi* was agreed "in which the former has concentrated on work with mothers and the under fives."

Probably the most important single factor within administrative policy which affects the health visitor's clientele is the policy of attachment to general practice. In the past the health visitor has obtained her clientele primarily through the notification of births to the Medical Officer of Health; in attachment an important potential source of clientele is the general practitioner. In this study 7·3% of visits were initiated by the general practitioner (some other studies, e.g. Gilmore (1970) have shown much higher proportions) but of these visits more than 60% were to households where there were no children under five and 40% were to families which the health visitor had not previously visited. The increasing use of age-sex registers in general practice is likely to increase still further the health visitor's opportunity for extending her clientele beyond that described in the stereotype.

12.2 *Content*

The outstanding feature of the content of the health visitor's home visits described in this study is the tremendous range of subject matter recorded. Fifty-one different topics were listed in the visit schedule; every topic listed occurred at least once and 165 further topics were recorded in the category "other"; but no single topic occurred in more than 40% of the visits. Some of the topics, such as specific illness and minor ailments, were essentially medical, and some, such as infant feeding and immunization, were within the scope of the stereotype of the content of health visiting, but very many were topics not traditionally associated with health visiting, e.g. behaviour problems of adolescents and adults, housing, employment, and legal problems. The content of visits to families with young children was, not surprisingly, quite different from the content of visits to the elderly, and did not appear to be limited by the overt or original purpose of the visit. It might be possible to postulate, as suggested by Johnson and Hardin (1962) "an ideal model of a home visit which might be depicted as a kind of unwritten agenda which implicitly states a framework of subject matter appropriate for the nurse to follow". It would certainly be valuable in an evaluation of standards of care to be able to compare the recorded frequency of certain topics with ideal models which postulated a priority of topics important in certain situations. In practice, however, the health visitor has to deal with whatever is presented to her as well as with topics which she might consider important in a particular situation; as Marris (1971) remarks: "Once face-to-face with a helpless or distressed or confused or impatient or angry person the health visitor must cope somehow with the topics raised, whatever the legal niceties of her function may be."

It is clear that the content of health visiting is much wider than that described in the stereotype. Topics not specifically concerned with young children were recorded in more than 80% of visits, and comprised more than half (57%) of all topics recorded. Even in the subgroup of visits made to households containing young children, topics not concerned with children were recorded in 74% of visits and comprised 44% of all topics recorded. Even in that part of the work which is concerned with families containing young children, the content of the work extends towards the wider definition of the term "maternal and child welfare" as discussed in Chapter 1.

Problems of physical health are clearly a major part of the health visitor's work. The physical development of children was recorded more frequently than their emotional development, and the physical health of antenatal and postnatal mothers more frequently than their mental and social well-being. Just over half (53·6%) of all topics recorded were concerned with physical aspects of health. In this respect the content of health visiting as described in this study conforms more closely to the stereotype than in the limitation to maternal and child welfare.

It is interesting, however, that the proportion of topics concerned with the psycho-social aspects of health was significantly increased in visits to families where there were no young children, in visits to families who were currently being visited by a social worker, and in visits initiated by the general practitioner. In visits to the elderly topics concerned with psychological aspects of health comprised 19·4% of all topics recorded, and topics concerned with social care 39·7%. In visits to "other" households topics concerned with psychological aspects comprised 23·7%, and topics concerned with social care comprised 41·7%. In both these groups, therefore, the psycho-social component considerably exceeded the physical health component. It is these groups which appear to be increasing as a proportion of the health visitor's clientele.

Moreover the relative importance of the three components depends not only on frequency of occurrence but also on time. Time spent on individual topics was not recorded in this study, but it is possibly significant that topics concerned with physical aspects of health comprised 61% of topics recorded in visits which lasted less than fifteen minutes compared with 35% in visits which lasted longer than an hour.

12.3 *Approach*

The validity of the assessment made in this study of the health visitor's approach to her clients is difficult to establish. "Approach" involves two people—the "approacher" and the "approached." Subjective assessment by the "approacher" of "level of verbal involvement" by means of a self-administered instrument must be regarded as an incomplete measure of "approach." Nevertheless the data recorded by this means showed a high level of internal agreement when subgroups of the total sample were compared, and a high level of expected findings when individual topics were compared.

Within this limitation, the evidence of this study does not support the stereotype. Overall the health visitor was found to be marginally more dominant than the client in terms of the initiation of subject matter; the health visitor initiated 57% of all topics recorded. There was considerable variation, however, in pattern of initiation of topics within different subject matter areas. Topics such as screening procedures, home safety, and care of the postnatal mother were almost always initiated by the health visitor; topics such as emotional or behaviour problems and marital disharmony were almost always initiated by the client.

In terms of "level of verbal involvement" the incidence of "advice" as opposed to "listening and reassurance" was low. As in the pattern of subject matter initiation there were considerable differences between the relative proportions in different subject matter areas. As might have been expected the health visitor appeared to be more "dominant" (i.e. gave advice as opposed to reassurance and factual information) in topics

concerned with physical health (22·3%) and in topics concerned specifically with young children (23·7%).

On both indices, younger and more recently trained health visitors were found to be less "dominant", i.e. to conform less closely to the stereotype, than older health visitors who qualified more than ten years ago.

12.4 *The Health Visitor as a Social Worker*

If health visiting does not conform with the stereotype held by other groups, to what extent does it conform with the preferred role of the health visitors in this study, that of a general medico-social worker? In the absence of an authoritative definition of general medico-social work conclusions can only be tentative. In 1964 a Joint Advisory Committee of the Council for the Training of Health Visitors and the Council for Training in Social Work stated: "The health visitor is a nurse and not a social worker, though her service contains an element of social work." The Seebohm Committee went further: "In our view the notion that health visitors might further become all-purpose social workers for general practice is mis-conceived." (Committee on Local Authority and Allied Personal Social Services 1968, para 380.)

The health visitors in this study believed that there was overlap between health visiting and social work and were unable to describe with any precision the differences between the two professions. Nearly half considered that they were qualified to do the work which social workers did, usually on the grounds that they were doing this already. Families with social problems constituted (jointly with young babies) the group of clients with whom they most enjoyed working, and supporting and counselling families ranked second among their preferred activities. The proportion of topics concerned with social care recorded in the home visits was considerable and was greater in visits to families where a social worker was currently visiting than in visits to families where no social worker was visiting. Families about which there was communication between health visitors and social workers were usually known either to the health visitor alone or to both. It is clear therefore that health visitors *are involved* in social work.

It is interesting, therefore, to compare the work of attached health visitors as described in this study with the work of attached social workers. Attachment of social workers to general practice is still at an experimental stage although the first scheme was reported as early as 1949. That general practice is an excellent "pickup" point for social as well as health problems has been noted by both health visitors and social workers. The Committe on Local Authority and Allied Personal Social Services (1968) remarked that: "During the next decade there may well be 6,000 health centres and group practices that could provide a proper base for such joint working (social worker attachment) and we

wish we could recommend a social worker to each of these. Unfortunately there is no evidence that general practice is ready for such a programme even if the workers were available." (Para. 699.) This view was endorsed in 1971 by the Harvard Davies report on The Organization of Group Practice. (Central Health Services Council 1971.) At present the training of social workers does not prepare them for work in general practice. Several experimental schemes have, however, been described, although it should be noted that in all the schemes so far reported the social worker has been a professionally qualified (graduate) caseworker, usually a medical social worker, whereas the training of the health visitor is probably more directly comparable with that of the non-graduate social worker who has undertaken the twenty-one month course of training leading to the Certificate in Social Work. Moreover in only one of the schemes reported was a social worker attached to a practice where an attached health visitor was already established, although in at least two schemes a health visitor joined the practice team during the course of the experiment.

McCulloch and Brown (1969) have reported a pilot study of an investigation of general practitioners' conceptions of the functions of social workers in general practice. Of the list of possible functions to be carried out by a social worker the respondents ranked the functions which they most desired as follows:

1. Supportive work with geriatric cases.
2. Organizing community help to keep patients out of hospital for as long as possible.
3. Supportive therapy (e.g. where general practitioner is treating depression by drugs).
4. Allaying fears of a non-pathological nature which are errationally held after reassurance by general practitioner.
5. Helping with housing problems.

The analysis in the present study of the purposes of visits made by health visitors and the subject matter discussed in them shows clearly that the health visitors in this study were undertaking all these functions, and it is of further interest that McCulloch and Brown found that 40% of their general practitioner respondents would prefer an attached social worker to be casework trained, while 60% would prefer the social worker "to have had training which originated in the nursing profession."

Goldberg *et al.* (1968) categorized the social worker's contribution to general practice under the three broad headings of diagnosis and assessment, casework, and the provision of links with social agencies. Cooper (1971) reiterated these three and added a fourth: that of helping to secure the patient's co-operation in medical care.

Cooper suggests that a general practitioner "will call for a social assessment (by the social worker) if he suspects that a patient's symptoms

are caused, aggravated or perpetuated by personal or family difficulties." The purpose of 106 (5·2%) of the visits in this study was recorded as "total assessment", of these, twenty-eight were initiated by the general practitioner and these constituted 18·7% of all visits initiated by the general practitioner. A working party set up by the Royal College of Nursing (1971) identified skills in observation and assessment as one of the core skills of health visiting and expressed the view that the combination of both medical and social knowledge with practice in assessment gained during previous nursing experience enabled the health visitor "to make the comprehensive assessment of a patient's need on which mobilization of appropriate resources must depend."

In describing the function of the attached social worker in the provision of links with social agencies, Cooper (1971) states: "The medical social worker . . . has acquired from her training a knowledge of the structure of local and national services. Furthermore, through her position in the public health team she maintains active liaison both with other health workers and with other local authority departments. She is in fact ideally placed to advise and assist patients in seeking help from either statutory or voluntary agencies." Exactly the same could be said of the attached health visitor. In the present study it was found that health visitors were in close contact with a great number and variety of other agencies. Following 25% of the visits recorded the health visitor either contacted some other agency or advised the client to do so, and in 15% of the visits the purpose of the visit was recorded as "to arrange services". The Council for the Training of Health Visitors specifically includes among the aims of the health visitor's training "to give a knowledge of various statutory and voluntary agencies which may assist in any particular family situation".

In describing the function of securing co-operation in medical care, Cooper (1971) mentions only the follow up of patients who fail to keep medical appointments. In the present study twenty-three visits were made specifically for this purpose. In addition to this function, however, it is clear that "securing co-operation in medical care" must include interpretation and explanation of medical advice, and maintenance of drug therapy. These subjects were not specifically listed as topics in the visit schedule, but "specific illness" occurred 550 times (an incidence of 26·7%) in the total sample of visits and 250 times (an incidence of 44%) in visits to families where the general practitioner was currently visiting. The knowledge of disease processes and of therapeutics which the health visitor gains during basic nurse training is essential for the performance of this function.

Three of the four functions ascribed to the attached social worker would appear, therefore, to be an integral part of the work of the attached health visitor. What of the fourth function, namely casework? Although the term is so difficult to define, it was frequently used by the health visitors in this study in their attempts to describe the difference

between health visiting and social work. The view was frequently expressed that in order to undertake casework the health visitor would require more training and more time (i.e. a smaller caseload); the relative importance of these two factors, however, was difficult to determine.

Forman and Fairbain (1968) categorized the work of the medical social worker attached to their practice under two headings:

1. A casework service for complex social and emotional situations surrounding illnesses or presenting in the guise of physical illness.
2. Effective mobilization of the social services.

They reported that in the experiment it was the casework skill of the medical social worker which had been her major contribution to the practice. They remarked: "Everyone caring for patients carries out 'casework' in some degree. It is the complexity of the situation which demands different degrees of skill and training. An individual with natural aptitude and interest in personal problems, whether trained as a nurse, health visitor, medical social worker, or doctor, can go further than one whose talents are for different work." (Forman and Fairbairn 1968, p. 47.)

The report of Forman and Fairbairn is of special interest because it describes an experiment in which one year after the attachment of a medical social worker, two health visitors were attached to the practice. The experiment continued for a further two years so that for the second half of the experiment the work of the health visitors and that of the medical social worker could be compared. The authors drew two main conclusions from the experience: "The first is that there was more than enough work for all three; all were pressed by claims on their services. Secondly the MSW and the HVs in the main carried out very different work, but there was an area of overlap in the work which might be carried out by either." (Forman and Fairbairn 1968, p. 44.)

The sector in which the authors found overlap was in dealing with individual patient problems; both health visitor and medical social worker were involved in assessment, mobilization of resources, listening, and support. The specific contribution of the medical social worker was casework and the mobilization of resources in "a highly selected group of cases which require a high proportion of time per case." (Forman and Fairbairn 1968, p. 46.)

The health visitors in the present study were working in practices to which no social workers were attached. If they had been working with attached social workers the work which they recorded would possibly have been different. It appears, however, that they were undertaking most of the functions ascribed to attached social workers, although the adequacy with which they were doing so is difficult to assess.

CHAPTER 13

The Future

13.1 *Recruitment and Retention*

In the long run the nature of the health visiting service will depend as much on the numbers of people who are available to staff the service as on the attitudes and policies of those responsible for its planning and administration. The potential opportunities for health visiting within general practice, for example, are probably infinite, but unless the ratio of health visitors to the practice population is adequate, the health visitor will be unable to utilize the opportunities available and the skills which her training has given her, and her work will tend to be limited to performance of traditional roles whatever changes there may be in training policies and philosophies of health care.

The need to recruit staff in the face of competition from other spheres of work is a problem for all the caring professions. The problem of recruitment to nursing has been exacerbated by the development of many other careers which offer opportunities for the exercise of compassion and skill in helping one's fellow man. Recruitment to health visiting is further limited by its dependence on recruitment to nursing. Recruitment, retention, and wastage therefore are questions which must be carefully considered in any discussion of the future of health visiting.

As long ago as 1956 the Jameson Report (Ministry of Health 1956) recommended a ratio of one health visitor to 4,300 population; the Working Party's Concept of the function of the health visitor depended on the availability of sufficient health visitors to meet this ratio, and they estimated that although such expansion would require particular attention to be paid to recruitment, this ratio was a realistic target. Under the Health Visitor and Social Work (Training) Act 1962, which followed government acceptance of the Jameson Report, the new Council for the Training of Health Visitors was specifically given the duty to attract suitable persons to training—a responsibility which is not shared by the other statutory bodies responsible for nurse training. The exercise of the responsibility by the Council resulted in an increase in the number of health visitor students in training from 621 in 1962 to 1,042 in 1970. (The Council 1971.)

Yet sixteen years after the publication of the Jameson Report the ratio which it suggested has rarely been achieved. In Berkshire at the time when this study was undertaken the ratio was approximately

1 : 5,000. In the London Boroughs the ratio ranges from 1 : 3,500 in Lewisham to 1 : 15,000 in Ealing. Hockey (1972) reported ratios which varied from 1 : 2,600 to 1 : 15,700.

Shortage produces a vicious circle. A health visitor who has to try to cope with an impossibly large caseload is barely able to fulfil her statutory duty to visit every new baby notified to her; she will be able to deal with problems only at the most superficial level, and will be quite unable to extend her role to include groups such as the elderly. The reduced job satisfaction which such a situation inevitably produces is a major cause of wastage, which in turn increases the shortage.

Several of the findings of this study have implications for recruitment policy. The age structure of the health visiting population of Berkshire is similar to that of the health visiting population as a whole, and this study appears to confirm the suggestion that health visiting is a career to which nurses come late in their professional lives, and to which, therefore, they bring wide professional experience. The high proportion of health visitors in the oldest age group, i.e. who were within five years of retirement, is a reflection of this occupational pattern, and must be a source of concern because of its implications for future staffing needs, particularly when it is related to the wastage associated with marriage and child bearing which must be expected in the youngest age groups.

The proportion of staff in this study who were married was more than double that recorded by Jefferys in Buckinghamshire in 1960. This is a reflection both of the increasing popularity of marriage and of the increasing proportion of married women who work. In 1968 more than half of the health visitor students in training were married. Information was not obtained in this study about numbers of dependent children, but half of the health visitors aged between thirty and forty were married and it is reasonable to suppose that some of these would have had dependent children. In this the very flexible conditions of service which Berkshire County Council offers, particularly to part-time staff, may be an important factor.

Health visiting is an activity which would appear to be highly amenable to the sort of limitations which family commitments impose. It is not an emergency service, does not require twenty-four hour availability, and is susceptible to individual planning; it can offer the *flexibility* of hours which may be more important to the working wife and mother than the *number* of hours required. The existence in the community of a pool of married nurses who would accept part-time employment in the community nursing services if suitable employment were offered to them has been demonstrated both by surveys such as that of Ramsden and Skeet (1967) and by the practical experience of the many general practitioners who employ, independently of the local authority nursing services, practice nurses. Yet Hockey (1972) found that the "family break" of health visitors was longer than that of district nurses, and that local authorities were more reluctant to appoint

part-time health visitors than part-time district nurses. The Council for the Education and Training of Health Visitors has recognized the need and is now providing special training courses for those with family commitments, but it would appear that local authorities need to follow the Council's example.

One further factor in recruitment and retention is the effect on job satisfaction of role definition. The Third Report of the Council for the Training of Health Visitors in 1967 noted: "It is obvious that candidates will make their decision to enter training on the appeal of the work and the lack of definition of the health visitor's role has been a barrier to many nurses." The lack of congruence between the health visitors' perceptions of their role and the perceptions held by others was one of the primary concerns of the present study. The great majority of health visitors in the present study enjoyed the "social work" component of their work and wanted to retain it for the future. They rejected the concept of the "community nurse", a role which many, in particular among general practitioners and social workers, are eager for the health visitor to adopt. There is clearly a conflict between what health visitors want to do and what other groups want them to do.

13.2 *An All-purpose Family Visitor*

Changes in the role of the health visitor during the past eentury have closely reflected changes in health needs and the development of health and social policy. During the nineteenth century, when the chief health problem was infectious disease, health legislation was concerned primarily with environmental controls, and the role adopted by the health visitor was that of "sanitary missioner." After the turn of the century the emphasis in social policy moved towards the development of personal health services, particularly those for children; the urgent problem was the high infant mortality rate, and the role of the health visitor changed from "sanitary missioner" to "well-baby nurse." The post-war period brought the introduction of a welfare state, rising standards of living and dramatic improvements in the physical health of children. The emphasis in health visiting accordingly began to move towards the emotional needs of children and the psycho-social aspects of health.

In 1956 the Jameson Report defined the function of the health visitor as "health education and social advice." The paragraph from which this book derives its title reads: "In association with the general practitioner the health visitor will be concerned with a wider range of families than any other comparable worker. She will be in touch with the various family health and welfare teams. She thus has the opportunity to act as a common point of reference and source of standard information, a common adviser on health teaching—a 'common factor' in family welfare. In the ordinary course of her work and without exceeding her

competence, she could be in a real sense a general purpose family visitor." (Ministry of Health 1956, Summary etc., para. X.)

The present study has demonstrated that the health visitor is concerned with a wide range of families, that she has frequent contact with the various health and social services, and that she discusses and advises on a very wide range of subject matter. Whatever the need which a family may present, the health visitor attempts to meet it, not so much because she is the best person to do so in every case, but because she is on the spot, and because, as this study and other studies have shown, there is usually nobody else.

It is this versatility of the health visitor which presents the greatest strength and at the same time the greatest danger for the future. The danger is that her versatility may lead to dissipation of her skills. Health visitors are often asked to undertake new tasks because they are already in an ideal position to do the job (e.g. the collection of data for health surveys), or because other staff are not available (clerical work, screening procedures, social casework).

In general practice in particular the pressures may be immense. Traditionally the health visitor has been chiefly concerned with primary and secondary prevention. General practitioners, on the other hand, have long been concerned with tertiary prevention, and some are beginning to develop their role in secondary prevention, but they are concerned hardly at all with primary prevention; for this reason many consider the health visitor's role in maternal and child welfare irrelevant, and would like her to devote her skills almost exclusively to the elderly and handicapped. It was suggested in Chapter 10 that the findings of this study did not support the fear, expressed by some who oppose attachment schemes, that the health visitor would be drawn from preventive into curative work. The real shift in emphasis, however, is not from preventative to curative work, but from primary prevention to tertiary prevention.

This study has noted the change in emphasis from work with mothers and young children to work with the elderly. The desirability of the change is debatable. Improved standards of living have without doubt reduced the necessity for the concentration on the physical health of children which was a feature of health visiting during the 1930s, but recent outbreaks of diseases such as diphtheria and the current annual rate of 10,000 hospital admissions of young children suffering from gastro-enteritis show that education about prophylaxis and hygiene is still necessary, and in depressed areas the health of children, both physical and emotional, is still inadequate compared with that of more privileged children.

Moreover, families with young children constitute an important vulnerable group within the population; the Seebohm Committee noted: "Various evidence suggests that it is in families which contain children under five (especially those with several children under five)

which experience many stresses and strains that not only make it difficult to provide an adequate environment for their children, but also place a family's harmony and survival in danger." (Committee on Local Authority and Allied Personal Social Services 1968, para. 498.)

In these families the health visitor has both the professional expertise and the opportunity to perform a vital role in primary and secondary prevention; in this she is unique among workers in the field of health and social welfare. The more work she undertakes with other groups, however, the less time she has available for this group.

Since it is unlikely that any dramatic increase in health visiting resources will occur in the foreseeable future, the health visitor must determine her own priorities within her individual caseload, and similarly the health visiting profession must determine its priorities within the service. No study has so far been carried out to compare the work of health visitors in an area where caseloads are high with the work in an area where the Jameson ratio has been achieved. It may be possible for a health visitor in Aberdeen, responsible for a population of 2,500 to adopt the role of an all purpose family visitor; for a health visitor in Ealing, responsible for a population of 15,700 it is clearly impossible to do so.

Herein lies the dilemma of health visiting. Changes in the training of health visitors made following the publication of the Jameson Report have equipped the health visitor for the wide role which the Jameson Committee envisaged. The development of attachment schemes has immeasurably increased the opportunities for the exercise of that role. The health visitors in this study wanted to adopt that role. But the caseloads which health visitors carry prevent it.

Summary of Findings

(a) *The Health Visitors Themselves*

1. Two-thirds of the health visitors were aged over forty years; more than a quarter (28%) were aged over fifty years.
2. Half of the health visitors were married; there were more married than single health visitors in all age groups except those aged over fifty years.
3. Four-fifths worked full-time; all but three of the part-timers were married, but two-thirds of the married health visitors were working full-time.
4. 60% had qualified as health visitors within the past ten years; 29% had been trained under the new (1965) syllabus.
5. 76% had more than minimum (SRN, HV) qualifications; 57% were qualified midwives and 34% were qualified district nurses.

(b) *Health Visiting as a Career*

6. 85% would in retrospect still go into health visiting. The reasons for becoming a health visitor which were most often mentioned spontaneously were regular hours, a desire to see the patient as a whole in his normal environment, and a desire to work outside hospital.
7. The decision to become a health visitor was usually taken late in the nursing career. Only 20% made the decision before or during their basic nurse training.
8. The parts of their work most enjoyed by the health visitors were visiting babies and children at home, and supporting and counselling families; the clients with whom they most enjoyed working were young babies and families with social problems. The activities recorded by most health visitors among their dislikes were group teaching and work in infant welfare clinics.
9. Of four possible roles suggested (community nurse, children's visitor, preventive health nurse, medico-social worker) 63% would choose that of medico-social worker; 80% rejected the community nurse role, 95% the children's visitor role, 45% the preventive health nurse role and 6% the medico-social worker role.

(c) *Health Visitors and Social Workers*

10. Health visitors had considerable contact with other agencies. Nearly half of the health visitors had been in contact with fifteen or more agencies during the past month and with ten or more agencies during the past week. All but one had been in contact with the general practitioner during the past week.
11. Only 30% of health visitors had any regular meetings with social workers.
12. Communication between health visitors and the four selected social agencies (Children's Department, Welfare Department, hospital medical social workers and voluntary organizations) was frequent. Almost half of the communications described had taken place within the past week, and about 85% within the past month.
13. Except in contact with medical social workers, more than three-quarters of the communications were initiated by health visitors; of communications with medical social workers three-quarters were initiated by medical social workers.
14. Almost a quarter of the health visitors spontaneously mentioned that they had never been contacted by the Children's Department, and almost a fifth that they had never been contacted by the Welfare Department. Only one health visitor mentioned that she had never been contacted by a medical social worker.
15. Except in contacts with voluntary organizations, the family about whom the communication took place was usually already known to both agencies.
16. 75% of health visitors considered there was some overlap between health visiting and social work. Half of them considered they were qualified to do the work which social workers did, but none considered social workers were qualified to do the work which health visitors did.
17. The health visitors were unable to describe with any precision the difference between health visiting and social work. Differences were most often described in terms of caseload size, depth (use of casework), problem orientation (the health visitor deals with normal families, the social worker only with problems), continuity of care (the social worker intervenes at a crisis and then withdraws).

(d) *The Pattern of the Health Visitor's Visits* (2,057 visits)

18. The health visitor most commonly visited families where there were young children, but a substantial minority (29%) of visits were to households where there were no young children; 18%

were to the elderly, and 11% to households where there were neither elderly nor young children.

19. In more than half of the visits (60%) the health visitor was thought to be the only visitor; this proportion was significantly higher in visits to householders containing young children.
20. The visit was usually made on the health visitor's own initiative. The client initiated 14% of visits, and the general practitioner 7%.
21. The purpose of the visit most commonly described was a routine visit to a child under five years, but these visits comprised only a quarter of the total.
22. Visits usually (79%) lasted less than half an hour; 28% lasted less than fifteen minutes, but a small number (3·4%) lasted longer than an hour.
23. 80% of visits were planned. Unplanned visits were usually the result of a chance meeting or a request from a client, and were usually brief, 44% lasting less than fifteen minutes.

(e) *The Content of the Home Visit*

24. All fifty-one topics listed were mentioned (lowest incidence 0·7%) plus many included under "other", but no topic was recorded in more than 37% of visits.
25. The topics most frequently recorded were infant feeding and the physical development of children, which were recorded in 36·8% and 35·9% of visits respectively. Of the ten topics most frequently recorded, five were specifically concerned with young children, but such topics comprised less than half of all topics recorded. Topics not specifically concerned with young children were recorded in more than 80% of all visits.
26. When topics were grouped into those concerned with physical aspects of health, those concerned with emotional aspects and those concerned with social aspects, "physical health" topics comprised 55% of all topics recorded; "emotional health" topics were recorded in 59% of all visits and comprised 19% of all topics; "social care" topics were recorded in 66% of all visits and comprised 26% of the total.
27. The proportion of topics concerned with emotional and social aspects of health was significantly increased in visits to households where there were no young children, in the visits initiated by the general practitioner, and in visits which lasted longer than an hour. The proportion of "social care" topics was significantly higher in visits to families where a social worker was known to be currently visiting than in families where no social worker was visiting.

28. Positive advice and teaching was given in 19% of all topics recorded; in 49% "listening and reassurance only" was given, and in 36% "discussion and factual information only" was given.

(f) *The Client's Part in the Interview*

29. 40% of all topics recorded were initiated by the client. The topics introduced by the client differed from those introduced by the health visitor. Physical development of children and infant feeding ranked in the top four in both groups, but housing, specific illness, emotional or behaviour problems of young children, financial inadequacy, employment and marital disharmony ranked in the twelve topics most frequently introduced by the client.

30. Clients in families where a social worker was known to be visiting raised a significantly higher proportion of "social care" topics than did clients in families where no social worker was visiting.

(g) *The Role of the General Practitioner*

31. The general practitioner initiated 7·3% of all visits. 60% of these visits were to families where there were no children, 39% of them to the elderly. In 40% of these visits the health visitor had not previously visited the family (compared with 18% in the total sample). The purposes most frequently recorded in visits initiated by the general practitioner were the provision of other services (24%), total assessment (19%), and child management (15%).

(h) *Differences According to the Age and Training of the Health Visitor*

32. There were significant differences between visits recorded by health visitors aged under forty years and those recorded by health visitors over forty years, and between visits recorded by health visitors who qualified since 1965 and those recorded by health visitors who qualified before 1960. Age and date of qualification were, not unnaturally, highly correlated, and therefore it was not always clear whether a particular difference was due to age or to training.

33. Recently qualified health visits recorded significantly fewer routine visits to children under five years and significantly more where the purpose was recorded as emotional support; they visited more babies, fewer toddlers, fewer elderly, and more "other" households; a higher proportion of their visits was initiated by the client and by the general practitioner.

34. Differences in topics recorded were difficult to assess because of factors such as differences in clientele which may overlay differences in the personal characteristics of the health visitor. There

was no significant difference in the relative proportions of the "physical", "emotional" and "social" components, but recently qualified health visitors recorded a significantly lower proportion of topics concerned specifically with children, and this difference appeared to be due to training not age.

35. The greatest differences were in the "dominance" of the health visitor in the interview. In visits recorded by recently qualified health visitors a significantly higher proportion of topics was introduced by the client, and the relative proportion of "positive advice and teaching" was significantly lower than in visits recorded by health visitors who qualified before 1960.

Appendix

Questionnaire for Health Visitors

This questionnaire is concerned with contact with other social agencies. By "contact" I mean both someone getting in touch with you and you getting in touch with them; this includes any sort of communication—letters, phone calls, and face to face discussion.

A. *General*

1. Which, if any, of the following social services have you had any contact with during the last month? Please put a tick alongside any which apply.

General practitioner	.....	Ministry of Social Security	.....
Midwife	.....	Housing Department	.....
District nurse	.....	Probation service	.....
Hospital MSW	.....	Police	.....
Hospital (other than MSW)	.....	Meals on Wheels	.....
Psychiatric social worker	.....	British Red Cross Soc.	.....
School health service	.....	W.R.V.S.	.....
Public health inspectors	.....	Family Planning Assn.	.....
Home help organizer	.....	Moral Welfare	.....
Children's Department	.....	N.S.P.C.C.	.....
Welfare Department	.....	Old People's Welfare Committee	.....
Education Department	.....		
Education Welfare Officer	.....		
Child guidance service	.....	Council of Social Service	.....

Other statutory service (specify).....

Other voluntary organization (specify).....

2. Which, if any of the following social services have you had any contact with during the last week? Please put a tick alongside any which apply.

General practitioner	.....	Ministry of Social Security	.....
Midwife	.....	Housing Department	.....
District nurse	.....	Probation service	.....
Hospital MSW	.....	Police	.....
Hospital (other than MSW)	.....	Meals on Wheels	.....
Psychiatric social worker	.....	British and Red Cross Soc.	.....
School health service	.....	W.R.V.S.	.....
Public health inspectors	.....	Family Planning Assn.	.....
Home help organizer	.....	Moral Welfare	.....
Children's Department	.....	N.S.P.C.C.	.....
Welfare Department	.....		

Education Department ..... Old People's Welfare
Education Welfare Officer ..... Committee .....
Child guidance service ..... Council of Social Service .....
Other statutory service (specify).....
Other voluntary organization (specify).....

B. *Children's Department*

3. Can you remember the most recent occasion when you were in touch with the Children's Department, that is any letter, meeting, or phone call either from them to you or from you to them?

Yes .....
No .....

If no, please answer question 4, then turn to question 13.
If yes, please omit question 4.

If "no" to question 3:

4. Can you think of any reasons why you have not had any contact with the Children's Department recently?

Yes .....
No .....

If yes, please specify:

If "yes" to question 3:

5. When was the most recent contact you had with the Children's Department? (tick one only)

within the last week .....
more than a week ago but within the last month .....
between one and six months ago .....
between six months and a year ago .....
more than a year ago .....

6. Who initiated this particular contact? (tick one only)

health visitor .....
Children's Department .....

7. What was the method of communication? (tick one only)

letter .....
phone conversation .....
face to face contact .....
other (specify) .....

8. What was this particular communication about?

9. Did they or you already know the family concerned? (tick one only)

known to health visitor only .....
known to Children's Department only .....
known to both .....
known to neither .....

10. About how often are you in touch with the Children's Department?

11. In general, what sort of things do you contact the Children's Department about?

12. What sort of things do they contact you about?

C. *Welfare Department*

13. Can you remember the most recent occasion when you were in touch with the Welfare Department, that is any meeting, letter, or phone call either from them to you or from you to them?

Yes .....
No .....

If no, please answer question 14, then turn to question 23.
If yes, please omit question 14.
If "no" to question 13:

14. Can you think of any reasons why you have not had any contact with the Welfare Department recently?

Yes .....
No .....

If yes, please specify:

15. When was the most recent contact you had with the Welfare Department? (tick one only)

within the last week .....
more than a week ago but within the last month .....
between one and six months ago .....
between six months and a year ago .....
more than a year ago .....

16. Who initiated this particular contact? (tick one only)

health visitor .....
Welfare Department .....

17. What was the method of communication? (tick one only)

letter .....
phone conversation .....
face to face contact .....
other (specify) .....

18. What was this particular communication about?

19. Did they or you already know the family concerned? (tick one only)

known to health visitor only .....
known to Welfare Department only .....
known to both .....
known to neither .....

20. About how often are you in touch with the Welfare Department?

21. In general, what sort of things do you contact the Welfare Department about?

22. What sort of things do they contact you about?

D. *Hospital Medical Social Workers*

23. Can you remember the most recent occasion when you were in touch with a hospital Medical Social Worker, that is any meeting, letter, or phone call either from a MSW to you or from you to a MSW?

Yes .....
No .....

If no, please answer question 24 and then turn to question 33.
If yes, please omit question 24.

If "no" to question 23:

24. Can you think of any reasons why you have not had any contact with Medical Social Workers recently?

Yes .....
No .....

If "yes" please specify:

If "yes" to question 23:

25. When was the most recent contact you had with a Medical Social Worker? (tick one only)

within the last week .....
more than a week ago but within the last month .....
between one and six months ago .....
between six months and a year ago .....
more than a year ago .....

26. Who initiated this particular contact? (tick one only)

health visitor .....
medical social worker .....

27. What was the method of communication? (tick one only)

letter .....
phone conversation .....
face to face contact .....
other (specify) .....

28. What was this particular communication about?

29. Did the Medical Social Worker or you already know the family concerned? (tick one only)

known to health visitor only .....
known to MSW only .....
known to both .....
known to neither .....

30. About how often would you say that you were in touch with a Medical Social Worker?

31. In general, what sort of things do you contact Medical Social Workers about?

32. What sort of things do they contact you about?

E. *Voluntary Organizations*

33. Can you remember the most recent occasion when you were in touch with a voluntary organization, that is any meeting, letter, or phone call either from a voluntary organization to you or from you to a voluntary organization?

Yes .....
No .....

If no, please answer question 34 and then turn to question 45.
If yes, please omit question 34.

If "no" to question 33:

34. Can you think of any reasons why you have not had any contact with voluntary organizations recently?

Yes .....
No .....

If yes, please specify:

If "yes" to question 33:

35. Which organization was it?

36. When did this particular contact take place? (tick one only)

within the last week .....
more than a week ago but within the last month .....
between one and six months ago .....
between six months and a year ago .....
more than a year ago .....

37. Who initiated this particular contact? (tick one only)

Health Visitor .....
voluntary organization .....

38. What was the method of communication? (tick one only)

letter .....
phone conversation .....
face to face contact .....
other (specify) .....

39. What was this particular communication about?

40. Did they or you already know the family concerned? (tick one only)

known to health visitor only .....
known to voluntary organization only .....
known to both .....
known to neither .....

41. About how often are you in touch with voluntary organizations?

42. Which voluntary organizations are you most often in touch with?

(i)
(ii)
(iii)

43. In general, what sort of things do you contact voluntary organizations about?

44. What sort of things do they contact you about?

F. *Meetings*

45. Do you have any regular meetings with social workers?

Yes .....
No .....

If yes:

How often do they take place? .....
What kind of meetings are they? .....

G. *Background Information*

The following details will help me to analyse the information in this questionnaire. It will be considered completely confidential and will not be used in any other way.

46. Age group (tick one only)

under 30	.....
30–39	.....
40–49	.....
50 and over	.....

47. Marital status (tick one only)

single	.....
married	.....
widowed	.....
other	.....

48. Where did you do your health visitor training?

49. In what year did you complete your health visitor training? .....

50. Do you work full-time or part-time? (tick one only)

full-time	.....
part-time	.....

51. Do you have any of the following qualifications in addition to the HV Certificate? (tick any which apply)

SCM	.....
QIDN	.....
RSCN	.....
RMN	.....
Fieldwork Instructor	.....
Other (specify)	.....

.....

Health Visiting Interview Schedule

1. Before you became a nurse, did you consider going into any occupation other than nursing?
   If yes:
   What occupation did you consider?
2. When did you decide to become a health visitor?
3. Can you tell me some of the reasons why you became a health visitor?
4. If you could have your time over again, would you still go into health visiting.
   Can you tell me why you say that?

5. I want to ask you next about which parts of health visiting you like best. On this card is a list of six activities which health visitors are called upon to perform. Could you put them in order of preference?
   (*a*) visiting babies and young children at home .....
   (*b*) advising on the prevention of disease and promotion of health .....
   (*c*) supporting and counselling families .....
   (*d*) work in infant welfare clinics .....
   (*e*) acting as information and referral agent .....
   (*f*) group teaching .....

6. Now I would like to ask you the same sort of question about different kinds of patients. I know we deal with all sorts of people, but I think most people do have preferences. This is a list of eight kinds of patients with whom health visitors deal. Can you put them in order of preference?
   (*a*) young babies .....
   (*b*) toddlers .....
   (*c*) families with social problems .....
   (*d*) physically handicapped .....
   (*e*) chronic sick .....
   (*f*) mentally ill .....
   (*g*) mentally subnormal .....
   (*h*) old people .....

7. Several suggestions have been made recently about what the future role of the health visitor might be, and I would like to know what you think of them.
   (*a*) One was that the health visitor should be a community nurse who would combine health visiting with skilled home nursing and the supervision of the home nursing done by State Enrolled Nurses.
   Can you tell me what you think of this suggestion?
   Can you tell me why you think that?
   (*b*) Another was that the health visitor should be a Children's Visitor whose responsibility would be for the physical and emotional development of children under five.
   Can you tell me what you think of this suggestion?
   Can you tell me why you think that?
   (*c*) Another suggestion was that she should be a medico-social worker for all age groups in addition to her special responsibility for children under five.
   Can you tell me what you think of this suggestion?
   Can you tell me why you think that?
   (*d*) Another was that the health visitor should be a preventive health nurse who would carry out existing duties in relation to infant care but would take on additional duties in screening procedures and an expanded amount of formal health education.
   Can you tell me what you think of this suggestion?
   Can you tell me why you think that?
   (*e*) At present health visiting includes something of all these roles, but if you could choose to perform one only, which one would you choose—the community nurse, the children's visitor, the medico-social worker, or the preventive health nurse?
   Can you tell me why you would choose that one?

8. Finally I would like to ask you some questions about health visiting and social work.
   (*a*) Would you say there was any overlap between health visiting and social work, or not?
   (*b*) What would you say was the difference between the sort of work that social workers do and the sort of work that you do?
   (*c*) Do you feel you are qualified to do the work that social workers do? Can you tell me why you feel that?
   (*d*) Do you feel social workers are qualified to do the work that you do? Can you tell me why you feel that?
   (*e*) Can you tell me anything about the sort of training that social workers have?

Visit Schedule

Details of this schedule are shown on the throwout opposite

Other	10
None	11

8. Approximately how long did this visit last?(tick one only)

less than 15 minutes	1
15 - 29 minutes	2
30 - 59 minutes	3
60 minutes or longer	4

9. Subsequent action (tick one only)

arrangements for follow-up visit	1
other agency contacted by HV(specify).....	2
client advised to contact other agency(specify)	3
none (record only)	4

10. Any other remarks

Please mark with a tick EVERY topic mentioned during this course of your visit:

a) Who introduced the topic? (tick one column only)

b) At what level was the topic dealt with?(tick one column only)

Level 1: Listening and reassurance only

Level 2: Discussion plus some factual information
e.g. services available, explanation of diagnosis or doctor's instructions, explanation of procedures, etc.

Level 3: Discussion plus some positive advice or teaching
e.g. advice to contact a G.P., advice as opposed to reassurance on infant feeding, teaching how to sterilize bottles.

Children under 5 years		INTRODUCED BY		LEVEL		
		HV	CLIENT	1	2	3
1 Diet - child under 1 year	1					
2 Diet - child 1 - 4 years	2					
3 Development - physical	3					
4 Development - mental and emotional	4					
5 Emotional or behaviour problem	5					
6 Immunization	6					
7 Screening procedure,	7					
8 Minor ailments	8					
9 Specific illness/defect/disability	9					
10 Daily minding/day nursery	10					
11 Play-group/nursery school	11					
12 Fostering/adoption	12					
13 Child cruelty or neglect	13					
14 Preparation for school	14					

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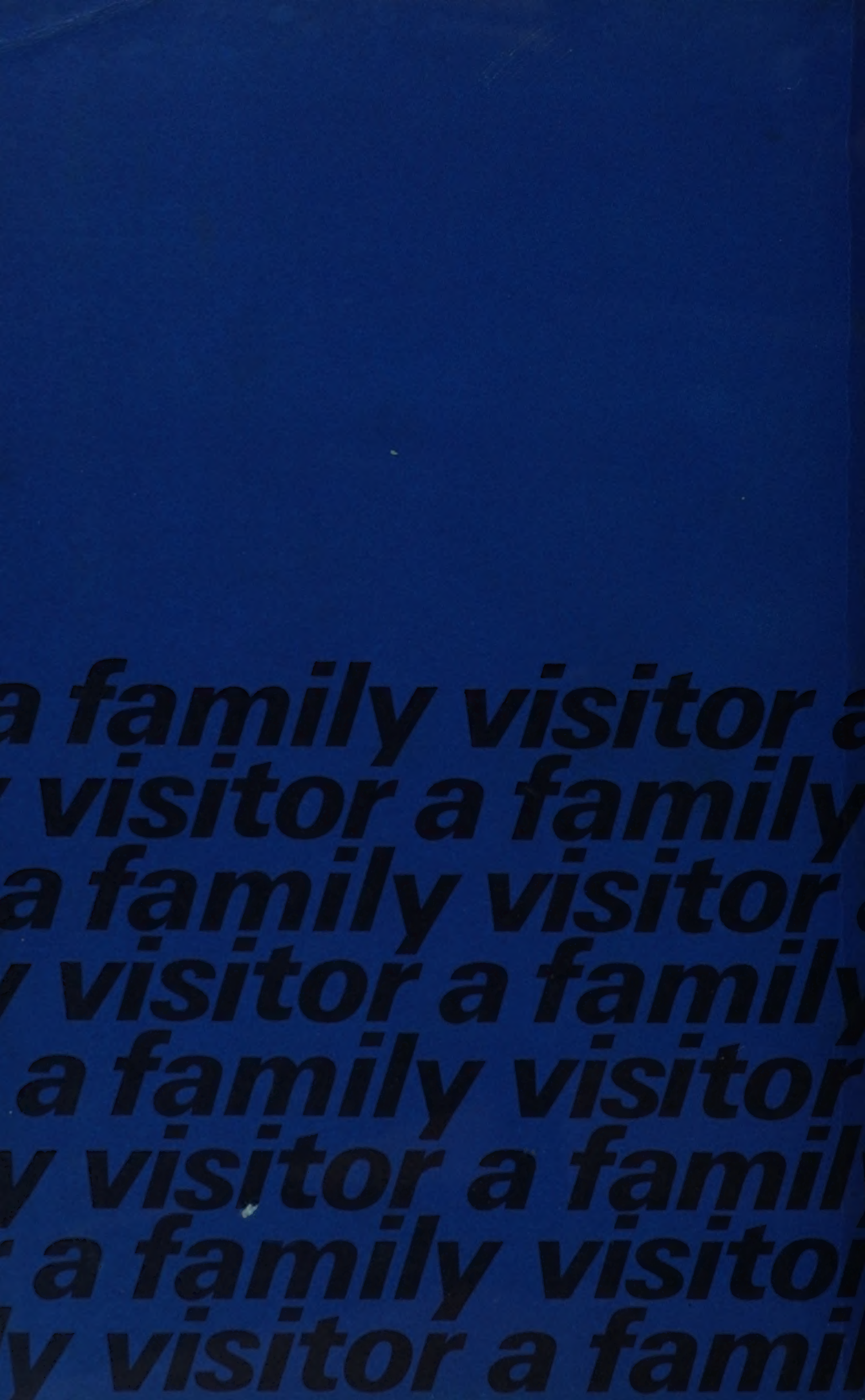
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